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Community Health Plan of Washington





2024 Dual Complete and Dual Select (HMO D-SNP) Prescription Drug Formulary (1 Tier)

COMMUNITY HEALTH PLAN of Washington™

MEDICARE ADVANTAGE

This formulary was updated on 11/19/2024. For more recent information or other questions, please contact Community Health Plan of Washington Dual Complete and Dual Select (HMO D-SNP) Customer Service at 1-800-942-0247 or for TTY users, dial 711, 7 days a week, 8 a.m. to 8 p.m. or visit our website at medicare.chpw.org. **Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information. **Important Message About What You Pay for Insulin** - You will pay $0 for a one-month supply of each insulin product covered by our plan.

November 2024

Community Health Plan of Washington

Medicare Advantage

Dual Complete and Dual Select Plans

(HMO D-SNP) 2024 Formulary

List of Covered Drugs

PLEASE READ: THIS DOCUMENT CONTAINS INFORMATION ABOUT THE DRUGS WE COVER IN THIS PLAN

HPMS Approved Formulary File Submission ID 00024250, Version Number 18

This formulary was updated on 11/19/2024. For more recent information or other questions, please contact Community Health Plan of Washington (CHPW) Dual Complete and Dual Select Plans Customer Service at 1-800-942-0247 or, for TTY users, dial 711, 7 days a week, 8 a.m. to 8 p.m., or visit medicare.chpw.org.

- **Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Customer Services for more information.
- **Important Message About What You Pay for Insulin** - You will pay $0 for a one-month supply of each insulin product covered by our plan.

Note to existing members: This formulary has changed since last year. Please review this document to make sure that it still contains the drugs you take.

When this drug list (formulary) refers to "we," "us", or "our," it means Community Health Plan of Washington. When it refers to "plan" or "our plan," it means Community Health Plan of Washington Dual Complete and Dual Select Plans (HMO D-SNP).

This document includes a list of the drugs (formulary) for our plan which is current as of 11/19/2024. For an updated formulary, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You must generally use network pharmacies to use your prescription drug benefit. Benefits, formulary, pharmacy network, and/or copayments/coinsurance may change on January 1, 2024, and from time to time during the year.

What is the Community Health Plan of Washington Dual Complete and Dual Select Plans Formulary?

A formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers, which represents the prescription therapies believed to be a necessary part of a quality treatment program. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a plan network pharmacy, and other plan rules are followed. For more information on how to fill your prescriptions, please review your Evidence of Coverage.

Can the Formulary (drug list) change?

Most changes in drug coverage happen on January 1, but we may add or remove drugs on the Drug List during the year, move them to different cost-sharing tiers, or add new restrictions. We must follow the Medicare rules in making these changes.

Changes that can affect you this year: In the below cases, you will be affected by coverage changes during the year:

- **New generic drugs.** We may immediately remove a brand-name drug on our Drug List if we are replacing it with a new generic drug that will appear on the same or lower cost-sharing tier and with the same or fewer restrictions. Also, when adding the new generic drug, we may decide to keep the brand-name drug on our Drug List, but immediately move it to a different cost-sharing tier or add new restrictions. If you are currently taking that brand-name drug, we may not tell you in advance before we make that change, but we will later provide you with information about the specific change(s) we have made.
    - If we make such a change, you or your prescriber can ask us to make an exception and continue to cover the brand-name drug for you. The notice we provide you will also include information on how to request an exception, and you can find information in the section below titled "How do I request an exception to the Community Health Plan of Washington Dual Complete and Dual Select Plans' Formulary?"

- **Drugs removed from the market.** If the Food and Drug Administration deems a drug on our formulary to be unsafe or the drug's manufacturer removes the drug from the market, we will immediately remove the drug from our formulary and provide notice to members who take the drug.

- **Other changes.** We may make other changes that affect members currently taking a drug. For instance, we may add a generic drug that is not new to market to replace a brand-name drug currently on the formulary or add new restrictions to the brand-name drug or move it to a different cost sharing tier or both. Or we may make changes based on new clinical guidelines. If we remove drugs from our formulary, or add prior authorization, quantity limits, and/or step therapy restrictions on a drug, we must notify affected members of the change at least 30 days before the change becomes effective, or at the time the member requests a refill of the drug, at which time the member will receive up to a 30-day supply of the drug.

    - If we make these other changes, you or your prescriber can ask us to make an exception and continue to cover the brand name drug for you. The notice we provide you will also include information on how to request an exception, and you can also find information in the section below entitled, "How do I request an exception to the Community Health Plan of Washington Dual Complete and Dual Select Plans' Formulary?"

Changes that will not affect you if you are currently taking the drug. Generally, if you are taking a drug on our 2024 formulary that was covered at the beginning of the year, we will not discontinue or reduce coverage of the drug during the 2024 coverage year except as described above. This means these drugs will remain available at the same cost sharing and with no new restrictions for those members taking them for the remainder of the coverage year. You will not get direct notice this year about changes that do not affect you. However, on January 1 of the next year, such changes would affect you, and it is important to check the Drug List for the new benefit year for any changes to drugs.

The enclosed formulary is current as of 11/19/2024. To get updated information about the drugs covered by our plan, please contact us. Our contact information appears on the front and back cover pages.

How do I use the Formulary?

There are two ways to find your drug within the formulary:

Medical Condition

The formulary begins on page 18. The drugs in this formulary are grouped into categories depending on the type of medical conditions that they are used to treat. For example, drugs used to treat a heart condition are listed under the category "Cardiovascular, Hypertension/Lipids." If you know what your drug is used for, look for the category name in the list that begins on page 18. Then look under the category name for your drug.

Alphabetical Listing

If you are not sure what category to look under, you should look for your drug in the Index that begins on page 84. The Index provides an alphabetical list of all of the drugs included in this document. Both brand name drugs and generic drugs are listed in the Index. Look in the Index and find your drug. Next to your drug, you will see the page number where you can find coverage information. Turn to the page listed in the Index and find the name of your drug in the first column of the list.

What are generic drugs?

Our plan covers both brand-name drugs and generic drugs. A generic drug is approved by the FDA as having the same active ingredient as the brand-name drug. Generally, generic drugs cost less than brand name drugs.

Are there any restrictions on my coverage?

Some covered drugs may have additional requirements or limits on coverage. These requirements and limits may include:

- **Prior Authorization:** Our plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval from our plan before you fill your prescriptions. If you don't get approval, the plan may not cover the drug.

- **Quantity Limits:** For certain drugs, our plan limits the amount of the drug that our plan will cover. For example, the plan provides 30 tablets per prescription for simvastatin. This may be in addition to a standard one-month or three-month supply.

- **Step Therapy:** In some cases, our plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, our plan may not cover Drug B unless you try Drug A first. If Drug A does not work for you, the plan will then cover Drug B.

You can find out if your drug has any additional requirements or limits by looking in the formulary that begins on page 18. You can also get more information about the restrictions applied to specific covered drugs by visiting our Web site. We have posted online documents that explain our prior authorization and step therapy restrictions. You may also ask us to send you a copy. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

You can ask our plan to make an exception to these restrictions or limits or for a list of other, similar drugs that may treat your health condition. See the section, "How do I request an exception to the Community Health Plan of Washington Dual Complete and Dual Select Plans' formulary?" on page 6 for information about how to request an exception.

What are over-the-counter (OTC) drugs?

OTC drugs are non-prescription drugs that are not normally covered by a Medicare Prescription Drug Plan. Community Health Plan of Washington Dual Complete Plan pays for certain OTC drugs. We cover, up to the plan benefit limit, non-prescription OTC products such as vitamins, sunscreen, and bandages. Community Health Plan of Washington Dual Complete Plan will provide these OTC drugs at no cost to you. The cost to the plan of these OTC drugs will not count toward your total Part D drug costs (that is, the cost of the OTC drugs does not count for the coverage gap).

What if my drug is not on the Formulary?

If your drug is not included in this formulary (list of covered drugs), you should first contact Customer Service and ask if your drug is covered.

If you learn that our plan does not cover your drug, you have two options:

- You can ask Customer Service for a list of similar drugs that are covered by our plan. When you receive the list, show it to your doctor and ask them to prescribe a similar drug that is covered by our plan.

- You can ask our plan to make an exception and cover your drug. See below for information about how to request an exception.

How do I request an exception to the Community Health Plan of Washington Dual Complete and Dual Select Plans' Formulary?

You can ask the plan to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover a drug even if it is not on our formulary. If approved, this drug will be covered at a pre-determined cost-sharing level, and you would not be able to ask us to provide the drug at a lower cost-sharing level.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, our plan limits the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover a greater amount.

Generally, our plan will only approve your request for an exception if the alternative drugs included on the plan's formulary or additional utilization restrictions would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

You should contact us to ask us for an initial coverage decision for a formulary or utilization restriction exception. **When you request a formulary or utilization restriction exception, you should submit a statement from your prescriber or physician supporting your request.** Generally, we must make our decision within 72 hours of getting your prescriber's supporting statement. You can request an expedited (fast) exception if you or your doctor believe that your health could be seriously harmed by waiting up to 72 hours for a decision. If your request to expedite is granted, we must give you a decision no later than 24 hours after we get a supporting statement from your doctor or other prescriber.

What do I do before I can talk to my doctor about changing my drugs or requesting an exception?

As a new or continuing member in our plan, you may be taking drugs that are not on our formulary. Or you may be taking a drug that is on our formulary, but your ability to get it is limited. For example, you may need a prior authorization from us before you can fill your prescription. You should talk to your doctor to decide if you should switch to an appropriate drug that we cover or request a formulary exception so that we will cover the drug you take. While you talk to your doctor to determine the right course of action for you, we may cover your drug in certain cases during the first 90 days you are a member of our plan.

For each of your drugs that is not on our formulary, or if your ability to get your drugs is limited, we will cover a temporary supply of up to 30 days. If your prescription is written for fewer days, we'll allow refills to provide up to a maximum 30-day supply of medication. After your first 30-day supply, we will not pay forthese drugs, even if you have been a member of the plan less than 90 days.

If you are a resident of a long-term care facility and you need a drug that is not on our formulary or if your ability to get your drugs is limited, but you are past the first 90 days of membership in our plan, we will cover a 31-day emergency supply of that drug while you pursue a formulary exception.

Our Policy Regarding Changes in Level of Care

You may have a change in your treatment setting due to the level of care you require. Such transitions include:

1. Being discharged from a hospital to a home;
2. Ending your skilled nursing facility Medicare Part A stay (where payments include all pharmacy charges) and now needing to use your Part D plan;
3. Giving up Hospice Status and reverting back to standard Medicare Part A and B coverage;
4. Being discharged from chronic psychiatric hospitals with highly individualized drug regimens;

For these unplanned transitions, you may need to request an exception or an appeal for continued coverage of your drug. In addition, we will review requests for continuation of therapy on a case-by-case basis if you have had a change in your level of care and are stabilized on drug regimens that if altered, are known to have risks.

Please see the Community Health Plan of Washington Transition Policy (medicare.chpw.org/member-center/member-resources/prescription-drug-coverage/) for more information.

Admission or discharge from a long-term care facility should not affect access to your Part D benefits.

For more information

For more detailed information about your Community Health Plan of Washington Dual Complete and Dual Select Plans prescription drug coverage, please review your Evidence of Coverage and other plan materials.

If you have questions about our plan, please contact us. Our contact information, along with the date we last updated the formulary, appears on the front and back cover pages.

If you have general questions about Medicare prescription drug coverage, please call Medicare at 1-800-MEDICARE (1-800-633-4227) 24 hours a day/7 days a week. TTY users should call 1-877-486-2048. Or visit http://www.medicare.gov.

Community Health Plan of Washington Dual Complete and Dual Select Plans Formulary

The formulary that begins on page 18 provides coverage information about the drugs covered by our plan. If you have trouble finding your drug in the list, turn to the Index that begins on page 84.

The first column of the chart lists the drug name. Brand name drugs are capitalized (e.g., RISPERDAL) and generic drugs are listed in lower-case italics (e.g., *risperidone*).

The information in the Requirements/Limits column tells you if our plan has any special requirements for coverage of your drug.

List of Abbreviations

- **BvD PA:** This prescription may be covered under Medicare Part B or Medicare Part D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make the determination.

- **LA:** Limited Availability. This prescription may be available only at certain pharmacies. For more information, consult your Pharmacy Directory or call Customer Service at 1-800-942-0247, 7 days a week, 8 a.m. to 8 p.m. TTY users should dial 711.

- **MO:** Mail-Order Drug. This prescription is available through our mail-order service, as well as our retail network pharmacies. Consider using mail-order for your long-term (maintenance) medications (such as high blood pressure medications). Retail network pharmacies may be more appropriate for short-term prescriptions, such as antibiotics.

- **PA:** Prior Authorization. The plan requires you or your physician to get prior authorization for certain drugs. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, we may not cover the drug.

- **ST:** Step Therapy. In some cases, the plan requires you to first try certain drugs to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may not cover Drug B unless you try Drug A first. If Drug A does not work for you, we will then cover Drug B.

- **QL:** Quantity Limit. For certain drugs, the plan limits the amount of the drug that we will cover.

Community Health Plan of Washington

Medicare Advantage

Planes Dual Complete y Dual Select

(HMO D-SNP) Formulario de 2024

Lista de medicamentos cubiertos

LEA: ESTE DOCUMENTO CONTIENE INFORMACIÓN SOBRE LOS MEDICAMENTOS QUE CUBRIMOS EN ESTE PLAN

HPMS Approved Formulary File Submission ID 00024250, Version Number 18

Este formulario se actualizó el 19/11/2024. Para obtener información actualizada o hacer alguna pregunta, comuníquese con el Servicio de atención al cliente de los planes Dual Complete y Dual Select de Community Health Plan of Washington (CHPW) al 1-800-942-0247 (los usuarios de TTY deben llamar al 711) los 7 días de la semana, de 8:00 a.m. a 8:00 p.m., o visite medicare.chpw.org.

- **Información importante sobre lo que paga por las vacunas**: Nuestro plan cubre la mayoría de las vacunas de la Parte D sin costo alguno. Para obtener más información, llame al Servicio de atención al cliente.
- **Información importante sobre lo que paga por la insulina**: Pagará $0 por el suministro para un mes de cada producto de insulina cubierto por nuestro plan.

Nota para miembros actuales: Este formulario ha cambiado desde el año pasado. Revise este documento para asegurarse de que todavía incluye los medicamentos que toma.

Cuando esta lista de medicamentos (formulario) dice “nosotros” “nos” o “nuestro”, hace referencia a Community Health Plan of Washington. Cuando menciona “plan” o “nuestro plan”, se refiere a los planes Dual Complete y Dual Select de Community Health Plan of Washington (HMO D-SNP).

Este documento incluye una lista de medicamentos (formulario) para nuestro plan que está vigente desde 19/11/2024. Para obtener un formulario actualizado, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

Por lo general, debe acudir a las farmacias de la red para usar el beneficio de medicamentos recetados. Los beneficios, el formulario, la red de farmacias, o los copagos/coseguros pueden cambiar el 1 de enero de 2024 y de vez en cuando durante el año.

¿Qué es el formulario de los planes Dual Complete y Dual Select de Community Health Plan of Washington?

Un formulario es una lista de medicamentos cubiertos seleccionados por nuestro plan, en colaboración con un equipo de proveedores de atención médica, que representa las terapias con receta que se consideran una parte necesaria de un programa de tratamiento de calidad. Generalmente cubriremos los medicamentos que se mencionan en nuestro formulario, siempre y cuando el medicamento sea médicamente necesario, la receta se presente en una farmacia de la red del plan y se cumpla con otras normas del plan. Para obtener más información sobre cómo surtir sus recetas, revise su Evidencia de cobertura.

¿Puede el Formulario (lista de medicamentos) cambiar?

La mayoría de los cambios en la cobertura de medicamentos se realizan el 1 de enero, pero podemos añadir

o retirar medicamentos de la lista de medicamentos durante el año, pasarlos a diferentes niveles de gastos compartidos o añadir nuevas restricciones. Debemos seguir las normas de Medicare a la hora de hacer estos cambios.

Los cambios que pueden afectarle este año: en los siguientes casos, se verá afectado por cambios los de cobertura durante el año:

- **Medicamentos genéricos nuevos.** Podemos retirar de inmediato un medicamento de marca de nuestra Lista de medicamentos si lo reemplazamos por un nuevo medicamento genérico que aparecerá en el mismo nivel de gasto compartido o en uno menor y con las mismas restricciones o menos. Además, al añadir el nuevo medicamento genérico, podemos decidir mantener el medicamento de marca en nuestra Lista de medicamentos, pero cambiarlo de inmediato a un nivel de gastos compartidos diferente o añadir nuevas restricciones. Si actualmente toma ese medicamento de marca, es posible que no informemos por adelantado que haremos ese cambio, pero luego le brindaremos información sobre los cambios específicos que hemos hecho.
    - Si implementamos dicho cambio, usted u otra persona autorizada a dar recetas pueden solicitarle al plan que realice una excepción y siga cubriendo el medicamento de marca para usted. La notificación que le brindamos también incluirá información sobre cómo solicitar una

excepción, además puede encontrar información en la sección a continuación titulada "¿Cómo solicito una excepción al formulario de los planes Dual Complete y Dual Select de Community Health Plan of Washington?"

- **Medicamentos retirados del mercado.** Si la Administración de Drogas y Alimentos (FDA) considera que un medicamento de nuestro formulario no es seguro, o si el fabricante del medicamento lo quita del mercado, eliminaremos inmediatamente dicho medicamento de nuestro formulario y enviaremos un aviso a los miembros que toman ese medicamento.

- **Otros cambios.** Podemos realizar otros cambios que afecten a los miembros que toman actualmente un medicamento. Por ejemplo, podríamos añadir un medicamento genérico que no sea nuevo en el mercado para reemplazar un medicamento de marca que figure actualmente en el formulario, o añadir nuevas restricciones al medicamento de marca o moverlo a un nivel de gastos compartidos diferente, o ambas opciones. O bien, podemos realizar cambios según nuevas pautas clínicas. Si retiramos medicamentos de nuestro formulario, o agregamos una autorización previa, límites de cantidad o restricciones de terapia escalonada a un medicamento, debemos notificar a los miembros afectados sobre el cambio, al menos 30 días antes de que el cambio esté vigente, o cuando el miembro solicite un resurtido del medicamento, en cuyo momento el miembro recibirá un suministro del medicamento para hasta 30 días.

    - Si realizamos estos cambios, usted y su proveedor pueden solicitar al plan que haga una excepción y siga cubriendo el medicamento de marca para usted. La notificación que le brindamos también incluirá información sobre cómo solicitar una excepción, y además puede encontrar información en la sección a continuación titulada "¿Cómo solicito una excepción al formulario de los planes Dual Complete y Dual Select de Community Health Plan of Washington?"

Cambios que no le afectarán si actualmente está tomando el medicamento. Por lo general, si toma un medicamento que se encuentra en nuestro formulario de 2024 que estaba cubierto al comienzo del año, no descontinuaremos ni reduciremos la cobertura del medicamento durante el año de cobertura 2024, excepto en los casos que se describieron anteriormente. Esto significa que estos medicamentos permanecerán disponibles con los mismos gastos compartidos y sin nuevas restricciones para aquellos miembros que los tomen durante el resto del año de cobertura. No recibirá un aviso directo sobre los cambios que no le afecten este año. Sin embargo, dichos cambios podrían afectarle a partir del 1 de enero del año siguiente, y es importante que revise la Lista de medicamentos del nuevo año de beneficios para ver los cambios.

El formulario adjunto está vigente desde 19/11/2024. Para obtener información actualizada sobre los medicamentos cubiertos por el plan, comuníquese con nosotros. Nuestra información de contacto aparece en las páginas de portada y contraportada.

¿Cómo uso el Formulario?

Existen dos maneras de buscar un medicamento dentro del formulario:

Afección médica

El formulario comienza en la página 18. En este formulario, los medicamentos se dividen en categorías según el tipo de afección médica que tratan. Por ejemplo, los medicamentos que se utilizan para tratar una afección cardíaca se enumeran bajo la categoría: “Cardiovascular, Hipertensión/Lípidos”. Si sabe para qué se utiliza su medicamento, busque el nombre de la categoría en la lista que comienza en la página 18. Luego, busque el nombre del medicamento debajo del nombre de la categoría.

Orden alfabético

Si no está seguro en qué categoría debe buscar, busque el medicamento en el índice que comienza en la página 84. El índice le proporciona una lista en orden alfabético de todos los medicamentos incluidos en este documento. Allí se enumeran los medicamentos de marca y los medicamentos genéricos. Busque en el índice y encuentre su medicamento. Al lado de medicamento, verá el número de página en donde puede encontrar la información de cobertura. Vaya a la página que figura en el índice y busque el nombre del medicamento en la primera columna de la lista.

¿Qué son los medicamentos genéricos?

Nuestro plan cubre medicamentos de marca y genéricos. La Administración de Alimentos y Medicamentos (FDA) aprueba un medicamento genérico cuando considera que contiene el mismo ingrediente activo que el medicamento de marca. En general, los medicamentos genéricos cuestan menos que los medicamentos de marca.

¿Existe alguna restricción en mi cobertura?

Algunos medicamentos cubiertos pueden tener requisitos o límites adicionales en la cobertura. Estos requisitos y límites pueden incluir:

- **Autorización previa:** Nuestro plan requiere que usted o su médico obtengan una autorización previa para ciertos medicamentos. Esto significa que deberá obtener la aprobación de nuestro plan antes de surtir sus recetas. Si no obtiene la aprobación, es posible que el plan no cubra el medicamento.

- **Límites en la cantidad:** Para ciertos medicamentos, nuestro plan limita la cantidad de medicamento que cubriremos. Por ejemplo, el plan ofrece 30 comprimidos por receta de simvastatina. Esto puede ser adicional a un suministro estándar de uno o tres meses.

- **Tratamiento escalonado:** En algunos casos, nuestro plan requiere que primero pruebe ciertos medicamentos para tratar su afección médica antes de que cubramos otro medicamento para su afección. Por ejemplo, si el medicamento A y el medicamento B tratan su afección médica, es posible que nuestro plan no cubra el medicamento B a menos que pruebe el medicamento A primero. Si el medicamento A no le funciona, entonces el plan cubrirá el medicamento B.

Puede averiguar si un medicamento tiene límites o requisitos adicionales al consultar el formulario que comienza en la página 18. También puede obtener más información sobre las restricciones que se aplican a medicamentos cubiertos específicos si visita nuestro sitio web. Hemos publicado documentos en línea que explican nuestras restricciones de autorización previa y tratamiento escalonado. También puede solicitar que le enviemos una copia. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

Puede solicitar que hagamos una excepción a estos límites o restricciones, o que le demos una lista de medicamentos similares que puedan utilizarse para tratar su afección médica. Consulte la sección “¿Cómo solicito una excepción al formulario de los planes Dual Complete y Dual Select de Community Health Plan of Washington?” en la página 5 para obtener más información sobre cómo solicitar una excepción.

¿Qué son los medicamentos de venta libre (OTC)?

Los medicamentos de venta libre son medicamentos sin receta que, por lo general, no están cubiertos por un plan de medicamentos recetados de Medicare. Plan de Dual Complete de Community Health Plan of Washington cubre ciertos medicamentos de venta libre. Cubrimos, hasta el límite de beneficios del plan, productos de venta libre sin receta, como vitaminas, protector solar y vendajes. Plan de Dual Complete de Community Health Plan of Washington le proporcionará estos medicamentos de venta libre sin costo alguno para usted. El costo para el plan de esos medicamentos OTC no contará en los costos de sus medicamentos de la Parte D (es decir, el costo de los medicamentos OTC no cuenta para la interrupción en la cobertura).

¿Qué pasa si mi medicamento no está en el formulario?

Si su medicamento no está incluido en este formulario (lista de medicamentos cubiertos), primero debe comunicarse con Servicio de atención al cliente y preguntar si su medicamento está cubierto.

Si se le comunica que el plan no cubre su medicamento, tiene dos opciones:

- Puede solicitar a Servicio de atención al cliente una lista de medicamentos similares cubiertos por el plan. Cuando reciba la lista, muéstresela a su médico y pídale que le recete un medicamento similar que esté cubierto por nuestro plan.

- Puede solicitar que hagamos una excepción y cubramos su medicamento. Consulte a continuación para obtener más información sobre cómo solicitar una excepción.

¿Cómo solicito una excepción al formulario de los planes Dual Complete y Dual Select de Community Health Plan of Washington?

Puede solicitar que hagamos una excepción a nuestras normas de cobertura. Hay varios tipos de excepciones que puede solicitarnos.

- Puede pedirnos que cubramos un medicamento incluso si no figura en nuestro formulario. Si se aprueba, este medicamento se cubrirá a un nivel de costo compartido predeterminado, y no podrá solicitarnos que proporcionemos el medicamento a un nivel de costo compartido menor.

- Puede pedirnos que no apliquemos los límites o restricciones de cobertura de su medicamento. Por ejemplo, para ciertos medicamentos, nuestro plan limita la cantidad de medicamento que cubriremos. Si su medicamento tiene un límite de cantidad, puede pedirnos que no apliquemos el límite y que cubramos un monto mayor.

En general, nuestro plan solo aprobará su solicitud de excepción si el medicamento alternativo incluido en el formulario del plan, o las restricciones de uso adicionales, no son tan efectivos para el tratamiento de su afección o si estos pueden causarle efectos médicos adversos.

Debe comunicarse con nosotros para solicitarnos una decisión de cobertura inicial sobre una excepción a nuestro formulario o a las restricciones de uso. **Cuando solicita una excepción a nuestro formulario o a las restricciones de uso, debe presentar una declaración de su médico o una persona autorizada a emitir recetas que respalde su solicitud.** Por lo general, debemos tomar una decisión en un plazo de 72 horas después de recibir la declaración de apoyo de su recetador. Puede solicitar una excepción acelerada (rápida) si usted o su médico creen que su salud podría ser perjudicada gravemente al esperar 72 horas por una decisión. Si se concede su solicitud de apelación acelerada, debemos comunicarle una decisión en un plazo máximo de 24 horas después de recibir una declaración de apoyo de su médico u otro recetador.

¿Qué hago antes de poder hablar con mi médico sobre cambiar de medicamentos o solicitar una excepción?

Como miembro nuevo o actual de nuestro plan, es posible que esté tomando medicamentos que no estén en nuestro formulario. O bien, puede estar tomando un medicamento que sí está en nuestro formulario,

pero su capacidad para obtenerlo es limitada. Por ejemplo, es posible que necesite una autorización previa de nuestra parte antes de que pueda surtir sus medicamentos recetados. Debe hablar con su médico para decidir si debe cambiar a un medicamento adecuado que cubramos o solicitar una excepción para el formulario para que cubramos el medicamento que toma. Mientras habla con su médico para determinar el curso de acción correcto para usted, podemos cubrir el medicamento en ciertos casos durante los primeros 90 días tras convertirse en un miembro del nuestro plan.

Para cada uno de los medicamentos que no estén en nuestro formulario, o si su acceso a estos medicamentos es limitado, cubriremos un suministro temporal de 30 días. Si su receta está indicada para menos días, permitiremos obtener varias veces los medicamentos hasta llegar a un máximo de un suministro para 30 días del medicamento. Luego de su primer suministro de 30 días, no pagaremos por estos medicamentos, incluso si usted ha sido miembro del plan durante menos de 90 días.

Si es un residente de un centro de atención a largo plazo y necesita un medicamento que no está en nuestro formulario, o si su acceso a estos medicamentos es limitado, pero ya ha superado los primeros 90 días como miembro de nuestro plan, cubriremos un suministro de emergencia de 31 días de ese medicamento mientras intenta obtener una excepción al formulario.

Nuestra política con respecto a los cambios en el nivel de atención

Puede haber cambios en el entorno de su tratamiento debido al nivel de atención que requiere. Dichas transiciones incluyen las siguientes:

1. ser dado de alta de un hospital a su casa;
2. finalizar su estadía en un establecimiento de enfermería especializada de la Parte A (en la que los pagos incluyen todos los cargos farmacéuticos) a raíz de una necesidad de usar su plan de la Parte D;
3. renunciar al Estado de necesidad de cuidados paliativos y volver a la cobertura de la Parte A y B estándar de Medicare;
4. ser dado de alta de hospitales psiquiátricos con regímenes altos de medicamentos individualizados.

Para estas transiciones no planificadas, es posible que necesite solicitar una excepción o apelación para una cobertura continua de su medicamento. Además, revisaremos las solicitudes de continuación del tratamiento sobre una base de caso por caso si ha tenido un cambio en el nivel de atención y si está estable en un régimen de medicamento que, si es alterado, tiene riesgos conocidos.

Lea la política de transición de Community Health Plan of Washington (medicare.chpw.org/member-center/member-resources/prescription-drug-coverage/) para obtener más información

La admisión o el alta de un establecimiento de cuidados a largo plazo no debería afectar sus beneficios de la Parte D.

Para obtener más información

Para obtener información más detallada sobre la cobertura de medicamentos recetados de los planes Dual Complete y Dual Select de Community Health Plan of Washington, revise su Evidencia de cobertura y otros materiales del plan.

Si tiene alguna pregunta sobre nuestro plan, comuníquese con nosotros. Nuestra información de contacto, junto con la fecha de la última actualización del formulario, aparece en las páginas de portada y contraportada.

Si tiene preguntas generales sobre la cobertura de medicamentos recetados de Medicare, llame al 1-800-MEDICARE (1-800-633-4227), disponible las 24 horas del día, los 7 días de la semana. Los usuarios de TTY deben llamar al 1-877-486-2048. O visite http://www.medicare.gov.

Formulario de los planes Dual Complete y Dual Select de Community Health Plan of Washington

El formulario que comienza en la página 18 ofrece información de cobertura sobre los medicamentos cubiertos en nuestro plan. Si tiene problemas para encontrar su medicamento en la lista, diríjase al índice que comienza en la página 84.

En la primera columna de la tabla aparece el nombre del medicamento. Los medicamentos de marca están escritos en mayúscula (por ejemplo, RISPERDAL) y los medicamentos genéricos están escritos en minúscula cursiva (por ejemplo, *risperidona*).

La información en la columna de Requisitos/límites indica si su plan tiene algún requisito especial para la cobertura de su medicamento.

Lista de abreviaturas

- **BvD PA:** esta receta puede estar cubierta por la Parte B o la Parte D de Medicare, según las circunstancias. Es posible que tenga que enviar información describiendo el uso y entorno del medicamento para realizar la determinación.

- **LA (Limited Availability):** disponibilidad limitada. Es posible que este medicamento recetado esté disponible solo en ciertas farmacias. Para obtener más información, consulte su Directorio de farmacias o llame al Servicio de atención al cliente al 1-800-942-0247, los 7 días de la semana, de 8:00 a.m. a 8:00 p.m. Los usuarios de TTY deben llamar al 711.

- **MO (Mail-Order):** medicamento de venta por correo. Esta receta está disponible a través de nuestro servicio de pedido por correo, así como de nuestras farmacias minoristas de la red. Considere utilizar el servicio de pedido por correo para sus medicamentos a largo plazo (medicamentos de mantenimiento), como los medicamentos para la presión arterial alta. Las farmacias minoristas de la red pueden ser más adecuadas para medicamentos recetados a corto plazo, como los antibióticos.

- **PA:** autorización previa. El plan requiere que usted o su médico obtengan una autorización previa para ciertos medicamentos. Esto significa que deberá obtener aprobación antes de surtir sus recetas. Si no obtiene la aprobación, puede que no cubramos el medicamento.

- **ST (Step Therapy):** tratamiento escalonado. En algunos casos, el plan requiere que pruebe ciertos medicamentos para tratar su afección médica antes de que cubramos otro medicamento para su afección. Por ejemplo, si el medicamento A y el medicamento B tratan la misma afección médica, es posible que no cubramos el medicamento B a menos que pruebe el medicamento A primero. Si el medicamento A no le funciona, entonces cubriremos el medicamento B.

- **QL (Quantity Limit):** límites en la cantidad. Para ciertos medicamentos, el plan limita la cantidad del medicamento que cubriremos.

COMMUNITY HEALTH PLAN OF WASHINGTON

2024 PRESCRIPTION DRUG FORMULARY (1TIER)

CURRENT AS OF 11/19/2024

Drug Name	Drug Tier	Requirements/ Limits
ANALGESICS		
ANALGESICS		
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	1	QL (360 EA per 30 days)
NONSTEROIDAL ANTI-INFLAMMATORY DRUGS		
celecoxib	1	
diclofenac potassium oral tablet 50 mg	1	
diclofenac sodium oral	1	
diflunisal	1	
etodolac oral capsule	1	
etodolac oral tablet	1	
flurbiprofen oral tablet 100 mg	1	
IBU ORAL TABLET 600 MG, 800 MG	1	
ibuprofen oral suspension	1	
ibuprofen oral tablet 400 mg, 600 mg, 800 mg	1	
meloxicam oral tablet	1	QL (30 EA per 30 days)
nabumetone	1	
naproxen oral tablet	1	
naproxen oral tablet,delayed release (dr/ec)	1	
oxaprozin oral tablet	1	
piroxicam	1	
sulindac	1	
OPIOID ANALGESICS, LONG-ACTING		
buprenorphine hcl sublingual	1	
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	1	PA; QL (10 EA per 30 days)
hydromorphone (pf) injection solution 10 mg/ml	1	QL (240 ML per 30 days)
hydromorphone oral tablet extended release 24 hr	1	PA; QL (60 EA per 30 days)
methadone oral solution 10 mg/5 ml	1	PA; QL (600 ML per 30 days)
methadone oral solution 5 mg/5 ml	1	PA; QL (1200 ML per 30 days)
methadone oral tablet 10 mg	1	PA; QL (120 EA per 30 days)
methadone oral tablet 5 mg	1	PA; QL (240 EA per 30 days)
morphine concentrate oral solution	1	QL (900 ML per 30 days)
morphine oral solution 10 mg/5 ml	1	QL (900 ML per 30 days)
morphine oral tablet 15 mg	1	QL (180 EA per 30 days)
morphine oral tablet extended release	1	PA; QL (120 EA per 30 days)
OPIOID ANALGESICS, SHORT-ACTING		
acetaminophen-codeine oral solution 120-12 mg/5 ml	1	QL (4500 ML per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
acetaminophen-codeine oral tablet 300-15 mg, 300-30 mg	1	QL (360 EA per 30 days)
acetaminophen-codeine oral tablet 300-60 mg	1	QL (180 EA per 30 days)
butorphanol nasal	1	QL (10 ML per 28 days)
ENDOCET ORAL TABLET 10-325 MG, 5-325 MG, 7.5-325 MG	1	QL (360 EA per 30 days)
fentanyl transdermal patch 72 hour 100 mcg/hr, 12 mcg/hr, 25 mcg/hr, 50 mcg/hr, 75 mcg/hr	1	PA; QL (10 EA per 30 days)
hydrocodone-acetaminophen oral solution 10-325 mg/15 ml, 7.5-325 mg/15 ml	1	QL (5550 ML per 30 days)
hydrocodone-acetaminophen oral tablet 10-300 mg, 5-300 mg, 7.5-300 mg	1	QL (390 EA per 30 days)
hydrocodone-acetaminophen oral tablet 10-325 mg, 5-325 mg, 7.5-325 mg	1	QL (360 EA per 30 days)
hydrocodone-ibuprofen oral tablet 7.5-200 mg	1	QL (50 EA per 30 days)
hydromorphone (pf) injection solution 10 mg/ml	1	QL (240 ML per 30 days)
hydromorphone oral liquid	1	QL (2400 ML per 30 days)
hydromorphone oral tablet	1	QL (180 EA per 30 days)
morphine concentrate oral solution	1	QL (900 ML per 30 days)
morphine oral solution	1	QL (900 ML per 30 days)
morphine oral tablet	1	QL (180 EA per 30 days)
oxycodone oral capsule	1	QL (360 EA per 30 days)
oxycodone oral concentrate	1	QL (180 ML per 30 days)
oxycodone oral solution	1	QL (1200 ML per 30 days)
oxycodone oral tablet 10 mg, 15 mg, 20 mg, 30 mg	1	QL (180 EA per 30 days)
oxycodone oral tablet 5 mg	1	QL (360 EA per 30 days)
oxycodone-acetaminophen oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	QL (360 EA per 30 days)
tramadol oral tablet 50 mg	1	QL (240 EA per 30 days)
tramadol-acetaminophen	1	QL (240 EA per 30 days)
ANESTHETICS		
LOCAL ANESTHETICS		
lidocaine hcl mucous membrane solution 4 % (40 mg/ml)	1	
lidocaine topical adhesive patch,medicated 5 %	1	PA; QL (90 EA per 30 days)
lidocaine topical ointment	1	QL (36 GM per 30 days)
LIDOCAINE VISCOUS	1	
lidocaine-prilocaine topical cream	1	QL (30 GM per 30 days)
LIDOCAN III	1	QL (90 EA per 30 days)
TRIDACAINE II	1	PA; QL (90 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
ANTI-ADDICTION/ SUBSTANCE ABUSE TREATMENT AGENTS		
ALCOHOL DETERRENTS/ANTI-CRAVING		
acamprosate	1	
disulfiram	1	
naltrexone	1	
VIVITROL	1	
OPIOID DEPENDENCE		
buprenorphine hcl sublingual	1	
buprenorphine-naloxone sublingual film 12-3 mg	1	QL (60 EA per 30 days)
buprenorphine-naloxone sublingual film 2-0.5 mg	1	QL (360 EA per 30 days)
buprenorphine-naloxone sublingual film 4-1 mg, 8-2 mg	1	QL (90 EA per 30 days)
buprenorphine-naloxone sublingual tablet 2-0.5 mg	1	QL (360 EA per 30 days)
buprenorphine-naloxone sublingual tablet 8-2 mg	1	QL (90 EA per 30 days)
naltrexone	1	
VIVITROL	1	
OPIOID REVERSAL AGENTS		
naloxone injection solution	1	
naloxone injection syringe 0.4 mg/ml, 1 mg/ml	1	

Drug Name	Drug Tier	Requirements/ Limits
SMOKING CESSATION AGENTS		
bupropion hcl (smoking deter)	1	
NICOTROL NS	1	
varenicline oral tablet 0.5 mg, 1 mg	1	
varenicline oral tablets,dose pack	1	
ANTIBACTERIALS		
AMINOGLYCOSIDES		
amikacin injection solution 500 mg/2 ml	1	PA
ARIKAYCE	1	PA; LA
gentamicin in nacl (iso-osm) intravenous piggyback 100 mg/100 ml, 60 mg/50 ml, 80 mg/100 ml, 80 mg/50 ml	1	PA
gentamicin injection solution 40 mg/ml	1	PA
gentamicin topical	1	QL (60 GM per 30 days)
neomycin	1	
streptomycin	1	PA; QL (60 EA per 30 days)
tobramycin inhalation	1	PA; QL (224 ML per 28 days)
tobramycin sulfate injection solution	1	PA
ANTIBACTERIALS, OTHER		
aztreonam	1	PA
clindamycin hcl	1	
clindamycin in 5 % dextrose	1	PA
clindamycin phosphate injection	1	PA

Drug Name	Drug Tier	Requirements/ Limits
clindamycin phosphate vaginal	1	
colistin (colistimethate na)	1	PA; QL (30 EA per 10 days)
daptomycin	1	
linezolid	1	
linezolid in dextrose 5%	1	PA
methenamine hippurate	1	
metronidazole in nacl (iso-os)	1	PA
metronidazole oral tablet	1	
metronidazole topical cream	1	
metronidazole topical gel	1	
metronidazole topical lotion	1	
metronidazole vaginal gel 0.75 % (37.5mg/5 gram)	1	
nitrofurantoin macrocrystal oral capsule 100 mg, 50 mg	1	
nitrofurantoin monohyd/m-cryst	1	
tigecycline	1	PA
tinidazole	1	
trimethoprim	1	
vancomycin intravenous recon soln 1,000 mg	1	PA; QL (20 EA per 10 days)
vancomycin intravenous recon soln 10 gram	1	PA; QL (2 EA per 10 days)
vancomycin intravenous recon soln 500 mg	1	PA; QL (10 EA per 10 days)
vancomycin intravenous recon soln 750 mg	1	PA; QL (27 EA per 10 days)
vancomycin oral capsule 125 mg	1	PA; QL (40 EA per 10 days)
vancomycin oral capsule 250 mg	1	PA; QL (80 EA per 10 days)
VANDAZOLE	1	
XIFAXAN ORAL TABLET 200 MG	1	QL (9 EA per 30 days)
XIFAXAN ORAL TABLET 550 MG	1	QL (90 EA per 30 days)
BETA-LACTAM, CEPHALOSPORINS		
cefaclor oral capsule	1	
cefaclor oral suspension for reconstitution 250 mg/5 ml	1	
cefadroxil oral capsule	1	
cefadroxil oral suspension for reconstitution 250 mg/5 ml, 500 mg/5 ml	1	
cefazolin injection recon soln 1 gram, 10 gram, 500 mg	1	
cefdinir	1	
cefepime injection	1	
cefixime	1	
cefoxitin	1	PA
cefpodoxime	1	
cefprozil	1	
ceftazidime	1	PA
ceftriaxone injection recon soln 1 gram, 10 gram, 2 gram, 250 mg, 500 mg	1	
cefuroxime axetil oral tablet	1	
cefuroxime sodium injection recon soln 750 mg	1	PA
cefuroxime sodium intravenous recon soln 1.5 gram	1	PA
cephalexin oral capsule 250 mg, 500 mg	1	
cephalexin oral suspension for reconstitution	1	

Drug Name	Drug Tier	Requirements/ Limits
TAZICEF INJECTION	1	PA
TEFLARO	1	PA
BETA-LACTAM, PENICILLINS		
amoxicillin oral capsule	1	
amoxicillin oral suspension for reconstitution	1	
amoxicillin oral tablet	1	
amoxicillin oral tablet,chewable 125 mg, 250 mg	1	
amoxicillin-pot clavulanate oral suspension for reconstitution	1	
amoxicillin-pot clavulanate oral tablet	1	
amoxicillin-pot clavulanate oral tablet extended release 12 hr	1	
ampicillin oral capsule 500 mg	1	
ampicillin sodium injection recon soln 1 gram, 10 gram, 125 mg	1	PA
ampicillin-sulbactam injection	1	PA
BICILLIN C-R	1	PA
BICILLIN L-A	1	PA
dicloxacillin	1	
nafcillin injection	1	PA
oxacillin	1	PA
oxacillin in dextrose(iso-osm)	1	PA
penicillin g potassium injection recon soln 20 million unit	1	PA
penicillin g sodium	1	PA
penicillin v potassium	1	

Drug Name	Drug Tier	Requirements/ Limits
piperacillin-tazobactam intravenous recon soln 2.25 gram, 3.375 gram, 4.5 gram, 40.5 gram	1	
CARBAPENEMS		
ertapenem	1	PA; QL (14 EA per 14 days)
imipenem-cilastatin	1	PA
meropenem intravenous recon soln 1 gram	1	PA; QL (30 EA per 10 days)
meropenem intravenous recon soln 500 mg	1	PA; QL (10 EA per 10 days)
MACROLIDES		
azithromycin intravenous	1	PA
azithromycin oral packet	1	
azithromycin oral suspension for reconstitution	1	
azithromycin oral tablet 250 mg, 500 mg, 600 mg	1	
clarithromycin	1	
DIFICID ORAL TABLET	1	QL (20 EA per 10 days)
E.E.S. 400 ORAL TABLET	1	
ERY-TAB ORAL TABLET,DELAYED RELEASE (DR/EC) 250 MG, 333 MG	1	
erythromycin ethylsuccinate oral tablet	1	
erythromycin oral	1	
QUINOLONES		
ciprofloxacin hcl ophthalmic (eye)	1	
ciprofloxacin hcl oral tablet 250 mg, 500 mg, 750 mg	1	

Drug Name	Drug Tier	Requirements/ Limits
ciprofloxacin in 5 % dextrose intravenous piggyback 200 mg/100 ml	1	PA
levofloxacin in d5w intravenous piggyback 500 mg/100 ml, 750 mg/150 ml	1	PA
levofloxacin oral	1	
moxifloxacin oral	1	
moxifloxacin-sod.chloride(iso)	1	PA
SULFONAMIDES		
sulfacetamide sodium (acne)	1	
sulfadiazine	1	
sulfamethoxazole-trimethoprim oral	1	
TETRACYCLINES		
DOXY-100	1	PA
doxycycline hyclate oral capsule	1	
doxycycline hyclate oral tablet 100 mg, 20 mg, 50 mg	1	
doxycycline monohydrate oral capsule 100 mg, 50 mg	1	
doxycycline monohydrate oral suspension for reconstitution	1	
doxycycline monohydrate oral tablet 100 mg, 50 mg, 75 mg	1	
minocycline oral capsule	1	
minocycline oral tablet	1	
tetracycline oral capsule	1	

Drug Name	Drug Tier	Requirements/ Limits
ANTICONVULSANTS		
ANTICONVULSANTS, OTHER		
BRIVIACT ORAL SOLUTION	1	QL (600 ML per 30 days)
BRIVIACT ORAL TABLET	1	QL (60 EA per 30 days)
DIACOMIT	1	PAns; LA
divalproex	1	
EPIDIOLEX	1	PAns; LA
EPRONTIA	1	PAns
felbamate	1	
FINTEPLA	1	PAns; LA; QL (360 ML per 30 days)
FYCOMPA ORAL SUSPENSION	1	QL (720 ML per 30 days)
FYCOMPA ORAL TABLET 10 MG, 12 MG, 8 MG	1	QL (30 EA per 30 days)
FYCOMPA ORAL TABLET 2 MG, 4 MG, 6 MG	1	QL (60 EA per 30 days)
lamotrigine oral tablet	1	
lamotrigine oral tablet, chewable dispersible	1	
lamotrigine oral tablet,disintegrating	1	
levetiracetam oral solution 100 mg/ml	1	
levetiracetam oral tablet	1	
levetiracetam oral tablet extended release 24 hr	1	
ROWEEPRA ORAL TABLET 500 MG	1	
SPRITAM	1	
SUBVENITE	1	
topiramate oral capsule, sprinkle	1	PAns
topiramate oral tablet	1	PAns

Drug Name	Drug Tier	Requirements/ Limits
valproic acid	1	
valproic acid (as sodium salt) oral solution 250 mg/5 ml	1	
XCOPRI MAINTENANCE PACK	1	QL (56 EA per 28 days)
XCOPRI ORAL TABLET 100 MG	1	QL (120 EA per 30 days)
XCOPRI ORAL TABLET 150 MG, 200 MG	1	QL (60 EA per 30 days)
XCOPRI ORAL TABLET 25 MG	1	QL (30 EA per 30 days)
XCOPRI ORAL TABLET 50 MG	1	QL (240 EA per 30 days)
XCOPRI TITRATION PACK	1	QL (28 EA per 180 days)
CALCIUM CHANNEL MODIFYING AGENTS		
CELONTIN ORAL CAPSULE 300 MG	1	
ethosuximide	1	
methsuximide	1	
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	1	QL (90 EA per 30 days)
pregabalin oral capsule 225 mg, 300 mg	1	QL (60 EA per 30 days)
pregabalin oral solution	1	QL (900 ML per 30 days)
ZONISADE	1	PAns
GAMMA-AMINOBUTYRIC ACID (GABA) AUGMENTING AGENTS		
clobazam oral suspension	1	PAns; QL (480 ML per 30 days)
clobazam oral tablet	1	PAns; QL (60 EA per 30 days)
clonazepam oral tablet 0.5 mg, 1 mg	1	QL (90 EA per 30 days)
clonazepam oral tablet 2 mg	1	QL (300 EA per 30 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	1	QL (90 EA per 30 days)
clonazepam oral tablet,disintegrating 2 mg	1	QL (300 EA per 30 days)
clorazepate dipotassium oral tablet 15 mg	1	PAns; QL (180 EA per 30 days)
clorazepate dipotassium oral tablet 3.75 mg	1	PAns; QL (90 EA per 30 days)
clorazepate dipotassium oral tablet 7.5 mg	1	PAns; QL (360 EA per 30 days)
DIAZEPAM INTENSOL	1	PAns; QL (240 ML per 30 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	1	PAns; QL (1200 ML per 30 days)
diazepam oral tablet	1	PAns; QL (120 EA per 30 days)
diazepam rectal	1	
gabapentin oral capsule 100 mg, 400 mg	1	QL (270 EA per 30 days)
gabapentin oral capsule 300 mg	1	QL (360 EA per 30 days)
gabapentin oral solution 250 mg/5 ml	1	QL (2160 ML per 30 days)
gabapentin oral tablet 600 mg	1	QL (180 EA per 30 days)
gabapentin oral tablet 800 mg	1	QL (120 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
LIBERVANT	1	PAns; QL (10 EA per 30 days)
LORAZEPAM INTENSOL	1	PA; QL (150 ML per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	1	PA; QL (90 EA per 30 days)
lorazepam oral tablet 2 mg	1	PA; QL (150 EA per 30 days)
NAYZILAM	1	PAns; QL (10 EA per 30 days)
phenobarbital	1	PAns
primidone oral tablet 250 mg, 50 mg	1	
SYMPAZAN	1	PAns; QL (60 EA per 30 days)
tiagabine	1	
VALTOCO	1	PAns; QL (10 EA per 30 days)
vigabatrin oral powder in packet	1	LA
vigabatrin oral tablet	1	PAns; LA
VIGADRONE ORAL POWDER IN PACKET	1	LA
VIGADRONE ORAL TABLET	1	PAns; LA
VIGPODER	1	PAns; LA
ZTALMY	1	PAns; LA; QL (1100 ML per 30 days)
SODIUM CHANNEL AGENTS		
APTIOM ORAL TABLET 200 MG	1	QL (180 EA per 30 days)
APTIOM ORAL TABLET 400 MG	1	QL (90 EA per 30 days)
APTIOM ORAL TABLET 600 MG, 800 MG	1	QL (60 EA per 30 days)
carbamazepine oral suspension 100 mg/5 ml	1	
carbamazepine oral tablet	1	
carbamazepine oral tablet extended release 12 hr	1	
carbamazepine oral tablet,chewable 100 mg	1	
DILANTIN	1	
EPITOL	1	
lacosamide oral solution	1	QL (1200 ML per 30 days)
lacosamide oral tablet 100 mg, 150 mg, 200 mg	1	QL (60 EA per 30 days)
lacosamide oral tablet 50 mg	1	QL (120 EA per 30 days)
oxcarbazepine oral suspension	1	
oxcarbazepine oral tablet	1	
phenytoin oral suspension 125 mg/5 ml	1	
phenytoin oral tablet,chewable	1	
phenytoin sodium extended	1	
rufinamide	1	PAns
zonisamide	1	PAns
ANTIDEMENTIA AGENTS		
ANTIDEMENTIA AGENTS, OTHER		
donepezil oral tablet 10 mg, 5 mg	1	
donepezil oral tablet,disintegrating	1	
NAMZARIC	1	PA

Drug Name	Drug Tier	Requirements/ Limits
CHOLINESTERASE INHIBITORS		
galantamine	1	
rivastigmine	1	
rivastigmine tartrate	1	
N-METHYL-D-ASPARTATE (NMDA) RECEPTOR ANTAGONIST		
memantine oral capsule,sprinkle,er 24hr	1	PA
memantine oral solution	1	PA
memantine oral tablet	1	PA
ANTIDEPRESSANTS		
ANTIDEPRESSANTS, OTHER		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML	1	QL (2.4 ML per 56 days)
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML	1	QL (3.2 ML per 56 days)
ABILIFY MAINTENA	1	QL (1 EA per 28 days)
aripiprazole oral solution	1	
aripiprazole oral tablet	1	QL (30 EA per 30 days)
aripiprazole oral tablet,disintegrating	1	QL (60 EA per 30 days)
AUVELITY	1	ST; QL (60 EA per 30 days)
bupropion hcl oral tablet	1	ST
bupropion hcl oral tablet extended release 24 hr 150 mg	1	ST; QL (90 EA per 30 days)
bupropion hcl oral tablet extended release 24 hr 300 mg	1	ST; QL (30 EA per 30 days)
bupropion hcl oral tablet sustained-release 12 hr	1	ST; QL (60 EA per 30 days)
mirtazapine	1	
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	QL (90 EA per 30 days)
quetiapine oral tablet 300 mg, 400 mg	1	QL (60 EA per 30 days)
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg	1	QL (30 EA per 30 days)
quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg	1	QL (60 EA per 30 days)
ZURZUVAE	1	PAns
MONOAMINE OXIDASE INHIBITORS		
EMSAM	1	
MARPLAN	1	
phenelzine	1	
tranylcypromine	1	
SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)		
citalopram oral solution	1	ST
citalopram oral tablet	1	ST; QL (30 EA per 30 days)
desvenlafaxine succinate	1	ST; QL (30 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	1	QL (60 EA per 30 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	1	QL (90 EA per 30 days)
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg	1	ST; QL (60 EA per 30 days)
escitalopram oxalate oral solution	1	ST
escitalopram oxalate oral tablet	1	ST; QL (30 EA per 30 days)
FETZIMA ORAL CAPSULE,EXT REL 24HR DOSE PACK 20 MG (2)- 40 MG (26)	1	QL (28 EA per 180 days)
FETZIMA ORAL CAPSULE,EXTENDED RELEASE 24 HR	1	QL (30 EA per 30 days)
fluoxetine oral capsule 10 mg	1	ST; QL (30 EA per 30 days)
fluoxetine oral capsule 20 mg	1	ST; QL (90 EA per 30 days)
fluoxetine oral capsule 40 mg	1	ST; QL (60 EA per 30 days)
fluoxetine oral solution	1	ST
fluvoxamine oral tablet 100 mg	1	ST; QL (90 EA per 30 days)
fluvoxamine oral tablet 25 mg	1	ST; QL (30 EA per 30 days)
fluvoxamine oral tablet 50 mg	1	ST; QL (60 EA per 30 days)
nefazodone	1	ST
paroxetine hcl oral suspension	1	ST
paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg	1	ST; QL (30 EA per 30 days)
paroxetine hcl oral tablet 30 mg	1	ST; QL (60 EA per 30 days)
sertraline oral concentrate	1	ST
sertraline oral tablet 100 mg, 50 mg	1	ST; QL (60 EA per 30 days)
sertraline oral tablet 25 mg	1	ST; QL (30 EA per 30 days)
trazodone	1	
TRINTELLIX	1	QL (30 EA per 30 days)
venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg	1	ST; QL (30 EA per 30 days)
venlafaxine oral capsule,extended release 24hr 75 mg	1	ST; QL (90 EA per 30 days)
venlafaxine oral tablet	1	ST; QL (90 EA per 30 days)
vilazodone	1	ST; QL (30 EA per 30 days)
TRICYCLICS		
amitriptyline	1	
amoxapine	1	
clomipramine	1	
desipramine	1	
doxepin oral capsule	1	
doxepin oral concentrate	1	
doxepin oral tablet	1	QL (30 EA per 30 days)
imipramine hcl	1	
imipramine pamoate	1	
nortriptyline	1	
protriptyline	1	
trimipramine	1	
ANTIEMETICS		
ANTIEMETICS, OTHER		
chlorpromazine oral	1	

Drug Name	Drug Tier	Requirements/ Limits
COMPRO	1	
meclizine oral tablet 12.5 mg, 25 mg	1	
metoclopramide hcl oral solution	1	
metoclopramide hcl oral tablet	1	
perphenazine	1	
prochlorperazine	1	
prochlorperazine maleate	1	
promethazine oral	1	PA
scopolamine base	1	
EMETOGENIC THERAPY ADJUNCTS		
aprepitant	1	BvD
dronabinol	1	BvD
EMEND ORAL SUSPENSION FOR RECONSTITUTION	1	BvD
granisetron hcl oral	1	BvD
ondansetron hcl oral solution	1	BvD
ondansetron hcl oral tablet 4 mg, 8 mg	1	BvD
ondansetron oral tablet,disintegrating 4 mg, 8 mg	1	BvD
VARUBI	1	BvD
ANTIFUNGALS		
ANTIFUNGALS		
ABELCET	1	BvD
amphotericin b	1	BvD
caspofungin	1	
ciclopirox topical cream	1	QL (90 GM per 28 days)
ciclopirox topical suspension	1	QL (60 ML per 28 days)
clotrimazole mucous membrane	1	

Drug Name	Drug Tier	Requirements/ Limits
clotrimazole topical cream	1	QL (45 GM per 28 days)
clotrimazole topical solution	1	QL (30 ML per 28 days)
CRESEMBA ORAL	1	PA
econazole	1	QL (85 GM per 28 days)
fluconazole	1	
fluconazole in nacl (iso-osm) intravenous piggyback 200 mg/100 ml, 400 mg/200 ml	1	PA
flucytosine	1	
griseofulvin microsize	1	
griseofulvin ultramicrosize	1	
itraconazole oral capsule	1	QL (120 EA per 30 days)
itraconazole oral solution	1	
ketoconazole oral	1	
ketoconazole topical cream	1	QL (60 GM per 28 days)
ketoconazole topical shampoo	1	QL (120 ML per 28 days)
micafungin	1	
NYAMYC	1	QL (180 GM per 30 days)
nystatin oral	1	
nystatin topical cream	1	QL (30 GM per 28 days)
nystatin topical ointment	1	QL (30 GM per 28 days)
nystatin topical powder	1	QL (180 GM per 30 days)
NYSTOP	1	QL (180 GM per 30 days)
posaconazole oral tablet,delayed release (dr/ec)	1	PA; QL (96 EA per 30 days)
terbinafine hcl oral	1	
terconazole	1	

Drug Name	Drug Tier	Requirements/ Limits
voriconazole	1	PA
ANTIGOUT AGENTS		
ANTIGOUT AGENTS		
allopurinol oral tablet 100 mg, 300 mg	1	
colchicine oral tablet	1	
febuxostat	1	
probenecid	1	
probenecid-colchicine	1	
ANTIMIGRAINE AGENTS		
ANTIMIGRAINE AGENTS		
NURTEC ODT	1	PA; QL (16 EA per 30 days)
ERGOT ALKALOIDS		
dihydroergotamine nasal	1	QL (8 ML per 28 days)
ergotamine-caffeine	1	
PROPHYLACTIC		
divalproex	1	
EMGALITY PEN	1	PA; QL (2 ML per 30 days)
EMGALITY SYRINGE SUBCUTANEOUS SYRINGE 120 MG/ML	1	PA; QL (2 ML per 30 days)
EPRONTIA	1	PAns
NURTEC ODT	1	PA; QL (16 EA per 30 days)
timolol maleate oral	1	
topiramate oral capsule, sprinkle	1	PAns
topiramate oral tablet	1	PAns
valproic acid	1	
valproic acid (as sodium salt) oral solution 250 mg/5 ml	1	

Drug Name	Drug Tier	Requirements/ Limits
SEROTONIN (5-HT) RECEPTOR AGONIST		
naratriptan	1	QL (18 EA per 28 days)
rizatriptan	1	QL (36 EA per 28 days)
sumatriptan nasal spray,non-aerosol 20 mg/actuation	1	QL (18 EA per 28 days)
sumatriptan nasal spray,non-aerosol 5 mg/actuation	1	QL (36 EA per 28 days)
sumatriptan succinate oral	1	QL (18 EA per 28 days)
sumatriptan succinate subcutaneous cartridge 6 mg/0.5 ml	1	QL (8 ML per 28 days)
sumatriptan succinate subcutaneous pen injector	1	QL (8 ML per 28 days)
sumatriptan succinate subcutaneous solution	1	QL (8 ML per 28 days)
ANTIMYASTHENIC AGENTS		
PARASYMPATHOMIMETICS		
pyridostigmine bromide oral tablet 60 mg	1	
pyridostigmine bromide oral tablet extended release	1	
ANTIMYCOBACTERIALS		
ANTIMYCOBACTERIALS, OTHER		
dapsone oral	1	
PRIFTIN	1	
rifabutin	1	
ANTITUBERCULARS		
ethambutol	1	

Drug Name	Drug Tier	Requirements/ Limits
isoniazid oral	1	
pyrazinamide	1	
rifampin	1	
SIRTURO	1	PA; LA
TRECATOR	1	
ANTINEOPLASTICS		
ALKYLATING AGENTS		
cyclophosphamide oral	1	BvD
GLEOSTINE	1	
LEUKERAN	1	
MATULANE	1	
VALCHLOR	1	PAns
ANTIANDROGENS		
abiraterone oral tablet 250 mg	1	PAns; QL (120 EA per 30 days)
abiraterone oral tablet 500 mg	1	PAns; QL (60 EA per 30 days)
bicalutamide	1	
ERLEADA ORAL TABLET 240 MG	1	PAns; QL (30 EA per 30 days)
ERLEADA ORAL TABLET 60 MG	1	PAns; QL (120 EA per 30 days)
nilutamide	1	PAns
NUBEQA	1	PAns; LA; QL (120 EA per 30 days)
toremifene	1	
XTANDI ORAL CAPSULE	1	PAns; QL (120 EA per 30 days)
XTANDI ORAL TABLET 40 MG	1	PAns; QL (120 EA per 30 days)
XTANDI ORAL TABLET 80 MG	1	PAns; QL (60 EA per 30 days)
YONSA	1	PAns; QL (120 EA per 30 days)
ANTIANGIOGENIC AGENTS		
lenalidomide	1	PAns; QL (28 EA per 28 days)
POMALYST	1	PAns; LA
REVLIMID	1	PAns; LA; QL (28 EA per 28 days)
THALOMID ORAL CAPSULE 100 MG	1	PAns; QL (112 EA per 28 days)
THALOMID ORAL CAPSULE 50 MG	1	PAns; QL (28 EA per 28 days)
ANTIESTROGENS/ MODIFIERS		
ORSERDU ORAL TABLET 345 MG	1	PAns; QL (30 EA per 30 days)
ORSERDU ORAL TABLET 86 MG	1	PAns; QL (90 EA per 30 days)
SOLTAMOX	1	
tamoxifen	1	
ANTIMETABOLITES		
DROXIA	1	
hydroxyurea	1	
INQOVI	1	PAns; QL (5 EA per 28 days)
mercaptopurine	1	
ONUREG	1	PAns; QL (14 EA per 28 days)
PURIXAN	1	

Drug Name	Drug Tier	Requirements/ Limits
TABLOID	1	
ANTINEOPLASTICS, OTHER		
GAVRETO	1	PAns; LA; QL (120 EA per 30 days)
IDHIFA	1	PAns; LA; QL (30 EA per 30 days)
IWILFIN	1	PAns; LA; QL (240 EA per 30 days)
JYLAMVO	1	BvD
KRAZATI	1	PAns; QL (180 EA per 30 days)
leucovorin calcium oral	1	
LONSURF	1	PAns
LUMAKRAS	1	PAns
LYNPARZA	1	PAns; QL (120 EA per 30 days)
LYSODREN	1	
methotrexate sodium	1	BvD
methotrexate sodium (pf) injection solution	1	BvD
NINLARO	1	PAns; QL (3 EA per 28 days)
OJJAARA	1	PAns; QL (30 EA per 30 days)
ORGOVYX	1	PAns; LA; QL (30 EA per 28 days)
RETEVMO ORAL CAPSULE 40 MG	1	PAns; LA; QL (180 EA per 30 days)
RETEVMO ORAL CAPSULE 80 MG	1	PAns; LA; QL (120 EA per 30 days)
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	1	PAns; LA; QL (60 EA per 30 days)
RETEVMO ORAL TABLET 40 MG	1	PAns; LA; QL (90 EA per 30 days)
TUKYSA ORAL TABLET 150 MG	1	PAns; LA; QL (120 EA per 30 days)
TUKYSA ORAL TABLET 50 MG	1	PAns; LA; QL (300 EA per 30 days)
VORANIGO ORAL TABLET 10 MG	1	PAns; QL (60 EA per 30 days)
VORANIGO ORAL TABLET 40 MG	1	PAns; QL (30 EA per 30 days)
WELIREG	1	PAns; LA
XATMEP	1	BvD
XPOVIO	1	PAns; LA
ZOLINZA	1	PAns; QL (120 EA per 30 days)
AROMATASE INHIBITORS, 3RD GENERATION		
anastrozole	1	
exemestane	1	
letrozole	1	
ENZYME INHIBITORS		
IBRANCE ORAL TABLET	1	PAns; QL (21 EA per 28 days)
OGSIVEO ORAL TABLET 100 MG, 150 MG	1	PAns; QL (56 EA per 28 days)
OGSIVEO ORAL TABLET 50 MG	1	PAns; QL (180 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
REZLIDHIA	1	PAns; QL (60 EA per 30 days)
TIBSOVO	1	PAns
MOLECULAR TARGET INHIBITORS		
AKEEGA	1	PAns; LA; QL (60 EA per 30 days)
ALECENSA	1	PAns; QL (240 EA per 30 days)
ALUNBRIG ORAL TABLET 180 MG, 90 MG	1	PAns; QL (30 EA per 30 days)
ALUNBRIG ORAL TABLET 30 MG	1	PAns; QL (60 EA per 30 days)
ALUNBRIG ORAL TABLETS,DOSE PACK	1	PAns; QL (30 EA per 180 days)
AUGTYRO	1	PAns; QL (240 EA per 30 days)
AYVAKIT	1	PAns; LA; QL (30 EA per 30 days)
BALVERSA	1	PAns; LA
BOSULIF ORAL CAPSULE 100 MG	1	PAns; QL (90 EA per 30 days)
BOSULIF ORAL CAPSULE 50 MG	1	PAns; QL (30 EA per 30 days)
BOSULIF ORAL TABLET 100 MG	1	PAns; QL (90 EA per 30 days)
BOSULIF ORAL TABLET 400 MG, 500 MG	1	PAns; QL (30 EA per 30 days)
BRAFTOVI	1	PAns; LA; QL (180 EA per 30 days)
BRUKINSA	1	PAns; LA
CABOMETYX	1	PAns; LA; QL (30 EA per 30 days)
CALQUENCE (ACALABRUTINIB MAL)	1	PAns; LA; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 100 MG	1	PAns; LA; QL (60 EA per 30 days)
CAPRELSA ORAL TABLET 300 MG	1	PAns; LA; QL (30 EA per 30 days)
COMETRIQ ORAL CAPSULE 100 MG/DAY(80 MG X1-20 MG X1)	1	PAns; QL (56 EA per 28 days)
COMETRIQ ORAL CAPSULE 140 MG/DAY(80 MG X1-20 MG X3)	1	PAns; QL (112 EA per 28 days)
COMETRIQ ORAL CAPSULE 60 MG/DAY (20 MG X 3/DAY)	1	PAns; QL (84 EA per 28 days)
COPIKTRA	1	PAns; LA; QL (60 EA per 30 days)
COTELLIC	1	PAns; LA; QL (63 EA per 28 days)
dasatinib oral tablet 100 mg, 140 mg, 50 mg, 80 mg	1	PAns; QL (30 EA per 30 days)
dasatinib oral tablet 20 mg, 70 mg	1	PAns; QL (60 EA per 30 days)
DAURISMO ORAL TABLET 100 MG	1	PAns; QL (30 EA per 30 days)
DAURISMO ORAL TABLET 25 MG	1	PAns; QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
ERIVEDGE	1	PAns; QL (30 EA per 30 days)
erlotinib oral tablet 100 mg, 150 mg	1	PAns; QL (30 EA per 30 days)
erlotinib oral tablet 25 mg	1	PAns; QL (60 EA per 30 days)
everolimus (antineoplastic) oral tablet	1	PAns; QL (30 EA per 30 days)
everolimus (antineoplastic) oral tablet for suspension 2 mg	1	PAns; QL (330 EA per 30 days)
everolimus (antineoplastic) oral tablet for suspension 3 mg	1	PAns; QL (240 EA per 30 days)
everolimus (antineoplastic) oral tablet for suspension 5 mg	1	PAns; QL (180 EA per 30 days)
everolimus (immunosuppressive)	1	BvD
FOTIVDA	1	PAns; LA; QL (21 EA per 28 days)
FRUZAQLA ORAL CAPSULE 1 MG	1	PAns; QL (84 EA per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG	1	PAns; QL (21 EA per 28 days)
GILOTRIF	1	PAns; QL (30 EA per 30 days)
IBRANCE ORAL CAPSULE	1	PAns; QL (21 EA per 28 days)
ICLUSIG	1	PAns; QL (30 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
imatinib oral tablet 100 mg	1	PAns; QL (180 EA per 30 days)
imatinib oral tablet 400 mg	1	PAns; QL (60 EA per 30 days)
IMBRUVICA ORAL CAPSULE 140 MG	1	PAns; QL (120 EA per 30 days)
IMBRUVICA ORAL CAPSULE 70 MG	1	PAns; QL (30 EA per 30 days)
IMBRUVICA ORAL SUSPENSION	1	PAns; QL (324 ML per 30 days)
IMBRUVICA ORAL TABLET 140 MG, 280 MG, 420 MG	1	PAns; QL (30 EA per 30 days)
INLYTA ORAL TABLET 1 MG	1	PAns; QL (180 EA per 30 days)
INLYTA ORAL TABLET 5 MG	1	PAns; QL (120 EA per 30 days)
INREBIC	1	PAns; LA; QL (120 EA per 30 days)
IRESSA	1	PAns; QL (30 EA per 30 days)
JAKAFI	1	PAns; QL (60 EA per 30 days)
JAYPIRCA ORAL TABLET 100 MG	1	PAns; QL (60 EA per 30 days)
JAYPIRCA ORAL TABLET 50 MG	1	PAns; QL (30 EA per 30 days)
KISQALI ORAL TABLET 200 MG/DAY (200 MG X 1)	1	PAns; QL (21 EA per 28 days)
KISQALI ORAL TABLET 400 MG/DAY (200 MG X 2)	1	PAns; QL (42 EA per 28 days)

Drug Name	Drug Tier	Requirements/ Limits
KISQALI ORAL TABLET 600 MG/DAY (200 MG X 3)	1	PAns; QL (63 EA per 28 days)
KOSELUGO	1	PAns
lapatinib	1	PAns; QL (180 EA per 30 days)
LAZCLUZE ORAL TABLET 240 MG	1	PAns; LA; QL (30 EA per 30 days)
LAZCLUZE ORAL TABLET 80 MG	1	PAns; LA; QL (60 EA per 30 days)
LENVIMA ORAL CAPSULE 10 MG/DAY (10 MG X 1), 4 MG	1	PAns; QL (30 EA per 30 days)
LENVIMA ORAL CAPSULE 12 MG/DAY (4 MG X 3), 18 MG/DAY (10 MG X 1-4 MG X2), 24 MG/DAY(10 MG X 2-4 MG X 1)	1	PAns; QL (90 EA per 30 days)
LENVIMA ORAL CAPSULE 14 MG/DAY(10 MG X 1-4 MG X 1), 20 MG/DAY (10 MG X 2), 8 MG/DAY (4 MG X 2)	1	PAns; QL (60 EA per 30 days)
LORBRENA ORAL TABLET 100 MG	1	PAns; QL (30 EA per 30 days)
LORBRENA ORAL TABLET 25 MG	1	PAns; QL (90 EA per 30 days)
MEKINIST ORAL RECON SOLN	1	PAns; QL (1260 ML per 30 days)
MEKINIST ORAL TABLET 0.5 MG	1	PAns; QL (90 EA per 30 days)
MEKINIST ORAL TABLET 2 MG	1	PAns; QL (30 EA per 30 days)
MEKTOVI	1	PAns; LA; QL (180 EA per 30 days)
NERLYNX	1	PAns; LA
ODOMZO	1	PAns; LA; QL (30 EA per 30 days)
OJEMDA ORAL SUSPENSION FOR RECONSTITUTION	1	PAns; QL (96 ML per 28 days)
OJEMDA ORAL TABLET 400 MG/WEEK (100 MG X 4)	1	PAns; QL (16 EA per 28 days)
OJEMDA ORAL TABLET 500 MG/WEEK (100 MG X 5)	1	PAns; QL (20 EA per 28 days)
OJEMDA ORAL TABLET 600 MG/WEEK (100 MG X 6)	1	PAns; QL (24 EA per 28 days)
pazopanib	1	PAns; QL (120 EA per 30 days)
PEMAZYRE	1	PAns; LA; QL (28 EA per 28 days)
PIQRAY	1	PAns
QINLOCK	1	PAns; LA; QL (90 EA per 30 days)
RETEVMO ORAL TABLET 120 MG, 160 MG, 80 MG	1	PAns; LA; QL (60 EA per 30 days)
RETEVMO ORAL TABLET 40 MG	1	PAns; LA; QL (90 EA per 30 days)
ROZLYTREK ORAL CAPSULE 100 MG	1	PAns; QL (150 EA per 30 days)
ROZLYTREK ORAL CAPSULE 200 MG	1	PAns; QL (90 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
ROZLYTREK ORAL PELLETS IN PACKET	1	PAns; QL (336 EA per 28 days)
RUBRACA ORAL TABLET 250 MG, 300 MG	1	PAns; LA; QL (120 EA per 30 days)
RYDAPT	1	PAns; QL (224 EA per 28 days)
SCEMBLIX ORAL TABLET 100 MG	1	PAns; QL (120 EA per 30 days)
SCEMBLIX ORAL TABLET 20 MG	1	PAns; QL (600 EA per 30 days)
SCEMBLIX ORAL TABLET 40 MG	1	PAns; QL (300 EA per 30 days)
sorafenib	1	PAns; QL (120 EA per 30 days)
SPRYCEL ORAL TABLET 100 MG, 140 MG, 50 MG, 80 MG	1	PAns; QL (30 EA per 30 days)
SPRYCEL ORAL TABLET 20 MG, 70 MG	1	PAns; QL (60 EA per 30 days)
STIVARGA	1	PAns; QL (84 EA per 28 days)
sunitinib malate	1	PAns; QL (30 EA per 30 days)
TABRECTA	1	PAns
TAFINLAR ORAL CAPSULE	1	PAns; QL (120 EA per 30 days)
TAFINLAR ORAL TABLET FOR SUSPENSION	1	PAns; QL (840 EA per 28 days)
TAGRISSO	1	PAns; LA; QL (30 EA per 30 days)
TALZENNA	1	PAns; QL (30 EA per 30 days)
TASIGNA ORAL CAPSULE 150 MG, 200 MG	1	PAns; QL (112 EA per 28 days)
TASIGNA ORAL CAPSULE 50 MG	1	PAns; QL (120 EA per 30 days)
TAZVERIK	1	PAns; LA
TEPMETKO	1	PAns; LA
TORPENZ	1	PAns; QL (30 EA per 30 days)
TRUQAP	1	PAns; QL (64 EA per 28 days)
TURALIO ORAL CAPSULE 125 MG	1	PAns; LA; QL (120 EA per 30 days)
VANFLYTA	1	PAns; QL (56 EA per 28 days)
VENCLEXTA ORAL TABLET 10 MG	1	PAns; LA; QL (60 EA per 30 days)
VENCLEXTA ORAL TABLET 100 MG	1	PAns; LA; QL (180 EA per 30 days)
VENCLEXTA ORAL TABLET 50 MG	1	PAns; LA; QL (30 EA per 30 days)
VENCLEXTA STARTING PACK	1	PAns; LA; QL (42 EA per 180 days)
VERZENIO	1	PAns; LA; QL (60 EA per 30 days)
VITRAKVI ORAL CAPSULE 100 MG	1	PAns; LA; QL (60 EA per 30 days)
VITRAKVI ORAL CAPSULE 25 MG	1	PAns; LA; QL (180 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
VITRAKVI ORAL SOLUTION	1	PAns; LA; QL (300 ML per 30 days)
VIZIMPRO	1	PAns; QL (30 EA per 30 days)
VONJO	1	PAns; QL (120 EA per 30 days)
VOTRIENT	1	PAns; QL (120 EA per 30 days)
XALKORI ORAL CAPSULE	1	PAns; QL (60 EA per 30 days)
XALKORI ORAL PELLET 150 MG	1	PAns; QL (180 EA per 30 days)
XALKORI ORAL PELLET 20 MG, 50 MG	1	PAns; QL (120 EA per 30 days)
XOSPATA	1	PAns; LA; QL (90 EA per 30 days)
ZEJULA ORAL TABLET 100 MG	1	PAns; LA; QL (90 EA per 30 days)
ZEJULA ORAL TABLET 200 MG, 300 MG	1	PAns; LA; QL (30 EA per 30 days)
ZELBORAF	1	PAns; QL (240 EA per 30 days)
ZYDELIG	1	PAns; QL (60 EA per 30 days)
ZYKADIA	1	PAns; QL (90 EA per 30 days)
RETINOIDS		
bexarotene	1	PAns
tretinoin (antineoplastic)	1	

Drug Name	Drug Tier	Requirements/ Limits
TREATMENT ADJUNCTS		
leucovorin calcium oral	1	
MESNEX ORAL	1	
ANTIPARASITICS		
ANTHELMINTICS		
albendazole	1	
EMVERM	1	
ivermectin oral	1	PA; QL (20 EA per 30 days)
praziquantel	1	
ANTIPROTOZOALS		
atovaquone	1	
atovaquone-proguanil	1	
chloroquine phosphate	1	
COARTEM	1	
hydroxychloroquine oral tablet 200 mg	1	
mefloquine	1	
nitazoxanide	1	
pentamidine inhalation	1	BvD; QL (1 EA per 28 days)
pentamidine injection	1	
pyrimethamine	1	PA
quinine sulfate	1	
ANTIPARKINSON AGENTS		
ANTICHOLINERGICS		
benztropine oral	1	PA
ANTIPARKINSON AGENTS, OTHER		
amantadine hcl oral capsule	1	
amantadine hcl oral solution	1	
carbidopa	1	

Drug Name	Drug Tier	Requirements/ Limits
carbidopa-levodopa-entacapone	1	
entacapone	1	
DOPAMINE AGONISTS		
bromocriptine	1	
NEUPRO	1	
pramipexole oral tablet	1	
ropinirole oral tablet	1	
DOPAMINE PRECURSORS AND/OR L-AMINO ACID DECARBOXYLASE INHIBITORS		
carbidopa	1	
carbidopa-levodopa	1	
INBRIJA INHALATION CAPSULE, W/INHALATION DEVICE	1	PA; QL (300 EA per 30 days)
MONOAMINE OXIDASE B (MAO-B) INHIBITORS		
rasagiline	1	
selegiline hcl	1	
ANTIPSYCHOTICS		
1ST GENERATION/TYPICAL		
chlorpromazine oral	1	
fluphenazine decanoate	1	
fluphenazine hcl	1	
haloperidol	1	
haloperidol decanoate intramuscular solution 100 mg/ml, 50 mg/ml	1	
haloperidol lactate injection	1	
haloperidol lactate oral	1	
loxapine succinate	1	
molindone	1	
perphenazine	1	
pimozide	1	
prochlorperazine maleate	1	
thioridazine	1	
thiothixene	1	
trifluoperazine	1	
2ND GENERATION/ATYPICAL		
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 720 MG/2.4 ML	1	QL (2.4 ML per 56 days)
ABILIFY ASIMTUFII INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 960 MG/3.2 ML	1	QL (3.2 ML per 56 days)
ABILIFY MAINTENA	1	QL (1 EA per 28 days)
aripiprazole oral solution	1	
aripiprazole oral tablet	1	QL (30 EA per 30 days)
aripiprazole oral tablet,disintegrating	1	QL (60 EA per 30 days)
ARISTADA INITIO	1	QL (4.8 ML per 365 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 1,064 MG/3.9 ML	1	QL (3.9 ML per 56 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 441 MG/1.6 ML	1	QL (1.6 ML per 28 days)

Drug Name	Drug Tier	Requirements/ Limits
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 662 MG/2.4 ML	1	QL (2.4 ML per 28 days)
ARISTADA INTRAMUSCULAR SUSPENSION,EXTENDED REL SYRING 882 MG/3.2 ML	1	QL (3.2 ML per 28 days)
asenapine maleate	1	QL (60 EA per 30 days)
CAPLYTA	1	QL (30 EA per 30 days)
FANAPT ORAL TABLET	1	QL (60 EA per 30 days)
FANAPT ORAL TABLETS,DOSE PACK	1	QL (8 EA per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,092 MG/3.5 ML	1	QL (3.5 ML per 180 days)
INVEGA HAFYERA INTRAMUSCULAR SYRINGE 1,560 MG/5 ML	1	QL (5 ML per 180 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 117 MG/0.75 ML	1	QL (0.75 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 156 MG/ML	1	QL (1 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 234 MG/1.5 ML	1	QL (1.5 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 39 MG/0.25 ML	1	QL (0.25 ML per 28 days)
INVEGA SUSTENNA INTRAMUSCULAR SYRINGE 78 MG/0.5 ML	1	QL (0.5 ML per 28 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 273 MG/0.88 ML	1	QL (0.88 ML per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 410 MG/1.32 ML	1	QL (1.32 ML per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 546 MG/1.75 ML	1	QL (1.75 ML per 90 days)
INVEGA TRINZA INTRAMUSCULAR SYRINGE 819 MG/2.63 ML	1	QL (2.63 ML per 90 days)
lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg	1	QL (30 EA per 30 days)
lurasidone oral tablet 80 mg	1	QL (60 EA per 30 days)
NUPLAZID	1	PAns; QL (30 EA per 30 days)
olanzapine intramuscular	1	
olanzapine oral	1	QL (30 EA per 30 days)
paliperidone oral tablet extended release 24hr 1.5 mg, 3 mg, 9 mg	1	QL (30 EA per 30 days)
paliperidone oral tablet extended release 24hr 6 mg	1	QL (60 EA per 30 days)
PERSERIS	1	QL (1 EA per 30 days)
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	QL (90 EA per 30 days)
quetiapine oral tablet 300 mg, 400 mg	1	QL (60 EA per 30 days)
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg	1	QL (30 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg	1	QL (60 EA per 30 days)
REXULTI ORAL TABLET	1	QL (30 EA per 30 days)
RISPERDAL CONSTA	1	QL (2 EA per 28 days)
risperidone microspheres	1	QL (2 EA per 28 days)
risperidone oral solution	1	
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	QL (60 EA per 30 days)
risperidone oral tablet 4 mg	1	QL (120 EA per 30 days)
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	QL (60 EA per 30 days)
risperidone oral tablet,disintegrating 4 mg	1	QL (120 EA per 30 days)
SECUADO	1	QL (30 EA per 30 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 100 MG/0.28 ML	1	QL (0.28 ML per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 125 MG/0.35 ML	1	QL (0.35 ML per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 150 MG/0.42 ML	1	QL (0.42 ML per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 200 MG/0.56 ML	1	QL (0.56 ML per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 250 MG/0.7 ML	1	QL (0.7 ML per 56 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 50 MG/0.14 ML	1	QL (0.14 ML per 28 days)
UZEDY SUBCUTANEOUS SUSPENSION,EXTENDED REL SYRING 75 MG/0.21 ML	1	QL (0.21 ML per 28 days)
VRAYLAR ORAL CAPSULE	1	QL (30 EA per 30 days)
ziprasidone hcl	1	QL (60 EA per 30 days)
ziprasidone mesylate	1	
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	1	QL (2 EA per 28 days)
TREATMENT-RESISTANT		
clozapine	1	
VERSACLOZ	1	
ANTISPASTICITY AGENTS		
ANTISPASTICITY AGENTS		
baclofen oral tablet	1	
dantrolene oral	1	
tizanidine oral tablet	1	

Drug Name	Drug Tier	Requirements/ Limits
ANTIVIRALS		
ANTI-CYTOMEGALOVIRUS (CMV) AGENTS		
PREVYMIS ORAL	1	QL (30 EA per 30 days)
valganciclovir	1	
ANTI-HEPATITIS B (HBV) AGENTS		
adefovir	1	
BARACLUDE ORAL SOLUTION	1	
entecavir	1	
lamivudine	1	
tenofovir disoproxil fumarate	1	
VEMLIDY	1	
VIREAD ORAL POWDER	1	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	1	
ANTI-HEPATITIS C (HCV) AGENTS		
EPCLUSA ORAL PELLETS IN PACKET 150-37.5 MG	1	PA; QL (28 EA per 28 days)
EPCLUSA ORAL PELLETS IN PACKET 200-50 MG	1	PA; QL (56 EA per 28 days)
EPCLUSA ORAL TABLET 200-50 MG	1	PA; QL (56 EA per 28 days)
EPCLUSA ORAL TABLET 400-100 MG	1	PA; QL (28 EA per 28 days)
HARVONI ORAL PELLETS IN PACKET 33.75-150 MG	1	PA; QL (28 EA per 28 days)
HARVONI ORAL PELLETS IN PACKET 45-200 MG	1	PA; QL (56 EA per 28 days)
HARVONI ORAL TABLET 90-400 MG	1	PA; QL (28 EA per 28 days)
ribavirin oral capsule	1	
ribavirin oral tablet 200 mg	1	
VOSEVI	1	PA; QL (28 EA per 28 days)
ANTIHERPETIC AGENTS		
acyclovir oral capsule	1	
acyclovir oral suspension 200 mg/5 ml	1	
acyclovir oral tablet	1	
acyclovir sodium intravenous solution	1	BvD
famciclovir	1	
trifluridine	1	
valacyclovir oral tablet 1 gram	1	QL (120 EA per 30 days)
valacyclovir oral tablet 500 mg	1	QL (60 EA per 30 days)
ANTI-HIV AGENTS, INTEGRASE INHIBITORS (INSTI)		
BIKTARVY	1	
DOVATO	1	
GENVOYA	1	
ISENTRESS	1	
ISENTRESS HD	1	
STRIBILD	1	
SYMTUZA	1	
TIVICAY ORAL TABLET 50 MG	1	
TIVICAY PD	1	

Drug Name	Drug Tier	Requirements/ Limits
ANTI-HIV AGENTS, NON-NUCLEOSIDE REVERSE TRANSCRIPTASE INHIBITORS (NNRTI)		
COMPLERA	1	
EDURANT	1	
efavirenz oral tablet	1	
etravirine	1	
INTELENCE ORAL TABLET 25 MG	1	
nevirapine oral suspension	1	
nevirapine oral tablet	1	
nevirapine oral tablet extended release 24 hr 400 mg	1	
PIFELTRO	1	
ANTI-HIV AGENTS, NUCLEOSIDE AND NUCLEOTIDE REVERSE TRANSCRIPTASE INHIBITORS (NRTI)		
abacavir	1	
abacavir-lamivudine	1	
CIMDUO	1	
DELSTRIGO	1	
DESCOVY	1	
efavirenz-emtricitabin-tenofov	1	
efavirenz-lamivu-tenofov disop	1	
emtricitabine	1	
emtricitabine-tenofovir (tdf)	1	
EMTRIVA ORAL SOLUTION	1	
JULUCA	1	
lamivudine	1	
lamivudine-zidovudine	1	
ODEFSEY	1	
tenofovir disoproxil fumarate	1	
VIREAD ORAL POWDER	1	
VIREAD ORAL TABLET 150 MG, 200 MG, 250 MG	1	
zidovudine	1	
ANTI-HIV AGENTS, OTHER		
FUZEON SUBCUTANEOUS RECON SOLN	1	
maraviroc	1	
RUKOBIA	1	
SELZENTRY ORAL SOLUTION	1	
SUNLENCA ORAL TABLET 300 MG	1	
TRIUMEQ	1	
TRIUMEQ PD	1	
ANTI-HIV AGENTS, PROTEASE INHIBITORS (PI)		
APTIVUS	1	
atazanavir	1	
EVOTAZ	1	
fosamprenavir	1	
lopinavir-ritonavir	1	
NORVIR ORAL POWDER IN PACKET	1	
PREZCOBIX	1	
PREZISTA ORAL SUSPENSION	1	

Drug Name	Drug Tier	Requirements/ Limits
PREZISTA ORAL TABLET 150 MG, 600 MG, 75 MG, 800 MG	1	
REYATAZ ORAL POWDER IN PACKET	1	
ritonavir	1	
VIRACEPT ORAL TABLET	1	
ANTI-INFLUENZA AGENTS		
amantadine hcl oral capsule	1	
amantadine hcl oral solution	1	
oseltamivir	1	
RELENZA DISKHALER	1	
rimantadine	1	
ANTIVIRALS		
LAGEVRIO (EUA)	1	QL (40 EA per 30 days)
PAXLOVID ORAL TABLETS,DOSE PACK 150-100 MG	1	QL (20 EA per 30 days)
PAXLOVID ORAL TABLETS,DOSE PACK 300 MG (150 MG X 2)-100 MG	1	QL (30 EA per 30 days)
ANXIOLYTICS		
ANXIOLYTICS, OTHER		
buspirone	1	
doxepin oral capsule	1	
doxepin oral concentrate	1	
doxepin oral tablet	1	QL (30 EA per 30 days)
hydroxyzine hcl oral tablet	1	PA
BENZODIAZEPINES		
clonazepam oral tablet 0.5 mg, 1 mg	1	QL (90 EA per 30 days)
clonazepam oral tablet 2 mg	1	QL (300 EA per 30 days)
clonazepam oral tablet,disintegrating 0.125 mg, 0.25 mg, 0.5 mg, 1 mg	1	QL (90 EA per 30 days)
clonazepam oral tablet,disintegrating 2 mg	1	QL (300 EA per 30 days)
clorazepate dipotassium oral tablet 15 mg	1	PAns; QL (180 EA per 30 days)
clorazepate dipotassium oral tablet 3.75 mg	1	PAns; QL (90 EA per 30 days)
clorazepate dipotassium oral tablet 7.5 mg	1	PAns; QL (360 EA per 30 days)
DIAZEPAM INTENSOL	1	PAns; QL (240 ML per 30 days)
diazepam oral solution 5 mg/5 ml (1 mg/ml)	1	PAns; QL (1200 ML per 30 days)
diazepam oral tablet	1	PAns; QL (120 EA per 30 days)
diazepam rectal	1	
LIBERVANT	1	PAns; QL (10 EA per 30 days)
LORAZEPAM INTENSOL	1	PA; QL (150 ML per 30 days)
lorazepam oral tablet 0.5 mg, 1 mg	1	PA; QL (90 EA per 30 days)
lorazepam oral tablet 2 mg	1	PA; QL (150 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
NAYZILAM	1	PAns; QL (10 EA per 30 days)
VALTOCO	1	PAns; QL (10 EA per 30 days)
SSRIS/SNRIS (SELECTIVE SEROTONIN REUPTAKE INHIBITORS/SEROTONIN AND NOREPINEPHRINE REUPTAKE INHIBITORS)		
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 20 MG, 30 MG, 60 MG	1	QL (60 EA per 30 days)
DRIZALMA SPRINKLE ORAL CAPSULE, DELAYED REL SPRINKLE 40 MG	1	QL (90 EA per 30 days)
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg	1	ST; QL (60 EA per 30 days)
escitalopram oxalate oral solution	1	ST
escitalopram oxalate oral tablet	1	ST; QL (30 EA per 30 days)
paroxetine hcl oral suspension	1	ST
paroxetine hcl oral tablet 10 mg, 20 mg, 40 mg	1	ST; QL (30 EA per 30 days)
paroxetine hcl oral tablet 30 mg	1	ST; QL (60 EA per 30 days)
sertraline oral concentrate	1	ST
sertraline oral tablet 100 mg, 50 mg	1	ST; QL (60 EA per 30 days)
sertraline oral tablet 25 mg	1	ST; QL (30 EA per 30 days)
venlafaxine oral capsule,extended release 24hr 150 mg, 37.5 mg	1	ST; QL (30 EA per 30 days)
venlafaxine oral capsule,extended release 24hr 75 mg	1	ST; QL (90 EA per 30 days)
venlafaxine oral tablet	1	ST; QL (90 EA per 30 days)
BIPOLAR AGENTS		
BIPOLAR AGENTS, OTHER		
asenapine maleate	1	QL (60 EA per 30 days)
lamotrigine oral tablet 25 mg	1	
lurasidone oral tablet 120 mg, 20 mg, 40 mg, 60 mg	1	QL (30 EA per 30 days)
lurasidone oral tablet 80 mg	1	QL (60 EA per 30 days)
olanzapine intramuscular	1	
olanzapine oral	1	QL (30 EA per 30 days)
PERSERIS	1	QL (1 EA per 30 days)
quetiapine oral tablet 100 mg, 200 mg, 25 mg, 50 mg	1	QL (90 EA per 30 days)
quetiapine oral tablet 300 mg, 400 mg	1	QL (60 EA per 30 days)
quetiapine oral tablet extended release 24 hr 150 mg, 200 mg	1	QL (30 EA per 30 days)
quetiapine oral tablet extended release 24 hr 300 mg, 400 mg, 50 mg	1	QL (60 EA per 30 days)
RISPERDAL CONSTA	1	QL (2 EA per 28 days)

Drug Name	Drug Tier	Requirements/ Limits
risperidone microspheres	1	QL (2 EA per 28 days)
risperidone oral solution	1	
risperidone oral tablet 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	QL (60 EA per 30 days)
risperidone oral tablet 4 mg	1	QL (120 EA per 30 days)
risperidone oral tablet,disintegrating 0.25 mg, 0.5 mg, 1 mg, 2 mg, 3 mg	1	QL (60 EA per 30 days)
risperidone oral tablet,disintegrating 4 mg	1	QL (120 EA per 30 days)
SECUADO	1	QL (30 EA per 30 days)
ziprasidone hcl	1	QL (60 EA per 30 days)
ziprasidone mesylate	1	
ZYPREXA RELPREVV INTRAMUSCULAR SUSPENSION FOR RECONSTITUTION 210 MG	1	QL (2 EA per 28 days)
MOOD STABILIZERS		
carbamazepine oral capsule, er multiphase 12 hr	1	
carbamazepine oral suspension 100 mg/5 ml	1	
carbamazepine oral tablet	1	
carbamazepine oral tablet extended release 12 hr 100 mg	1	
carbamazepine oral tablet,chewable 100 mg	1	
divalproex	1	
EPITOL	1	
lamotrigine oral tablet 100 mg, 150 mg, 200 mg	1	
lamotrigine oral tablet, chewable dispersible	1	
lamotrigine oral tablet,disintegrating	1	
lithium carbonate	1	
lithium citrate	1	
SUBVENITE	1	
valproic acid	1	
valproic acid (as sodium salt) oral solution 250 mg/5 ml	1	
BLOOD GLUCOSE REGULATORS		
ANTIDIABETIC AGENTS		
acarbose oral tablet 100 mg	1	QL (90 EA per 30 days)
acarbose oral tablet 25 mg	1	QL (360 EA per 30 days)
acarbose oral tablet 50 mg	1	QL (180 EA per 30 days)
BYDUREON BCISE	1	PA; QL (4 ML per 28 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 10 MCG/DOSE(250 MCG/ML) 2.4 ML	1	PA; QL (2.4 ML per 30 days)
BYETTA SUBCUTANEOUS PEN INJECTOR 5 MCG/DOSE (250 MCG/ML) 1.2 ML	1	PA; QL (1.2 ML per 30 days)
colesevelam	1	
FARXIGA ORAL TABLET 10 MG	1	QL (30 EA per 30 days)
FARXIGA ORAL TABLET 5 MG	1	QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
glimepiride oral tablet 1 mg	1	QL (240 EA per 30 days)
glimepiride oral tablet 2 mg	1	QL (120 EA per 30 days)
glimepiride oral tablet 4 mg	1	QL (60 EA per 30 days)
glipizide oral tablet 10 mg	1	QL (120 EA per 30 days)
glipizide oral tablet 5 mg	1	QL (240 EA per 30 days)
glipizide oral tablet extended release 24hr 10 mg	1	QL (60 EA per 30 days)
glipizide oral tablet extended release 24hr 2.5 mg	1	QL (240 EA per 30 days)
glipizide oral tablet extended release 24hr 5 mg	1	QL (120 EA per 30 days)
glipizide-metformin oral tablet 2.5-250 mg	1	QL (240 EA per 30 days)
glipizide-metformin oral tablet 2.5-500 mg, 5-500 mg	1	QL (120 EA per 30 days)
GVOKE	1	
GVOKE HYPOPEN 2-PACK	1	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	1	
JANUMET	1	QL (60 EA per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 100-1,000 MG	1	QL (30 EA per 30 days)
JANUMET XR ORAL TABLET, ER MULTIPHASE 24 HR 50-1,000 MG, 50-500 MG	1	QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
JANUVIA	1	QL (30 EA per 30 days)
JARDIANCE	1	QL (30 EA per 30 days)
metformin oral tablet 1,000 mg	1	QL (75 EA per 30 days)
metformin oral tablet 500 mg	1	QL (150 EA per 30 days)
metformin oral tablet 850 mg	1	QL (90 EA per 30 days)
metformin oral tablet extended release 24 hr 500 mg	1	QL (120 EA per 30 days)
metformin oral tablet extended release 24 hr 750 mg	1	QL (60 EA per 30 days)
nateglinide oral tablet 120 mg	1	QL (90 EA per 30 days)
nateglinide oral tablet 60 mg	1	QL (180 EA per 30 days)
pioglitazone	1	QL (30 EA per 30 days)
repaglinide oral tablet 0.5 mg	1	QL (960 EA per 30 days)
repaglinide oral tablet 1 mg	1	QL (480 EA per 30 days)
repaglinide oral tablet 2 mg	1	QL (240 EA per 30 days)
saxagliptin	1	QL (30 EA per 30 days)
saxagliptin-metformin oral tablet, er multiphase 24 hr 2.5-1,000 mg	1	QL (60 EA per 30 days)
saxagliptin-metformin oral tablet, er multiphase 24 hr 5-1,000 mg, 5-500 mg	1	QL (30 EA per 30 days)
SYNJARDY	1	QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 25-1,000 MG	1	QL (30 EA per 30 days)
SYNJARDY XR ORAL TABLET, IR - ER, BIPHASIC 24HR 12.5-1,000 MG, 5-1,000 MG	1	QL (60 EA per 30 days)
TRULICITY	1	PA; QL (2 ML per 28 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 10-1,000 MG, 10-500 MG	1	QL (30 EA per 30 days)
XIGDUO XR ORAL TABLET, IR - ER, BIPHASIC 24HR 2.5-1,000 MG, 5-1,000 MG, 5-500 MG	1	QL (60 EA per 30 days)
BLOOD GLUCOSE REGULATORS		
GVOKE	1	
GVOKE HYPOPEN 2-PACK	1	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	1	
GLYCEMIC AGENTS		
diazoxide	1	
GVOKE	1	
GVOKE HYPOPEN 2-PACK	1	
GVOKE PFS 1-PACK SYRINGE SUBCUTANEOUS SYRINGE 1 MG/0.2 ML	1	
KORLYM	1	PA
mifepristone oral tablet 300 mg	1	PA

Drug Name	Drug Tier	Requirements/ Limits
INSULINS		
GAUZE PAD TOPICAL BANDAGE 2 X 2 "	1	
HUMALOG JUNIOR KWIKPEN U-100	1	
HUMALOG KWIKPEN INSULIN	1	
HUMALOG MIX 50-50 KWIKPEN	1	
HUMALOG MIX 75-25 KWIKPEN	1	
HUMALOG MIX 75-25(U-100)INSULN	1	
HUMALOG U-100 INSULIN SUBCUTANEOUS CARTRIDGE	1	
HUMALOG U-100 INSULIN SUBCUTANEOUS SOLUTION	1	BvD
HUMULIN 70/30 U-100 INSULIN	1	
HUMULIN 70/30 U-100 KWIKPEN	1	
HUMULIN N NPH INSULIN KWIKPEN	1	
HUMULIN N NPH U-100 INSULIN	1	
HUMULIN R REGULAR U-100 INSULN	1	
HUMULIN R U-500 (CONC) INSULIN	1	
HUMULIN R U-500 (CONC) KWIKPEN	1	
insulin lispro subcutaneous solution	1	BvD
insulin syringe-needle u-100 syringe 0.3 ml 29 gauge, 1 ml 29 gauge x 1/2", 1/2 ml 28 gauge	1	

Drug Name	Drug Tier	Requirements/ Limits
LANTUS SOLOSTAR U-100 INSULIN	1	
LANTUS U-100 INSULIN	1	
LYUMJEV KWIKPEN U-100 INSULIN	1	
LYUMJEV KWIKPEN U-200 INSULIN	1	
LYUMJEV U-100 INSULIN	1	BvD
pen needle, diabetic needle 29 gauge x 1/2"	1	
SOLIQUA 100/33	1	QL (90 ML per 30 days)
TOUJEO MAX U-300 SOLOSTAR	1	
TOUJEO SOLOSTAR U-300 INSULIN	1	
BLOOD PRODUCTS AND MODIFIERS		
ANTICOAGULANTS		
dabigatran etexilate	1	
ELIQUIS	1	
ELIQUIS DVT-PE TREAT 30D START	1	
enoxaparin subcutaneous syringe 100 mg/ml, 150 mg/ml	1	QL (28 ML per 28 days)
enoxaparin subcutaneous syringe 120 mg/0.8 ml, 80 mg/0.8 ml	1	QL (22.4 ML per 28 days)
enoxaparin subcutaneous syringe 30 mg/0.3 ml, 60 mg/0.6 ml	1	QL (16.8 ML per 28 days)
enoxaparin subcutaneous syringe 40 mg/0.4 ml	1	QL (11.2 ML per 28 days)
fondaparinux	1	

Drug Name	Drug Tier	Requirements/ Limits
heparin (porcine) injection solution	1	
JANTOVEN	1	
warfarin	1	
XARELTO	1	
XARELTO DVT-PE TREAT 30D START	1	
BLOOD PRODUCTS AND MODIFIERS, OTHER		
anagrelide	1	
DROXIA	1	
LEUKINE INJECTION RECON SOLN	1	PA
NIVESTYM	1	PA
NYVEPRIA	1	PA
PROCRIT INJECTION SOLUTION 10,000 UNIT/ML, 2,000 UNIT/ML, 20,000 UNIT/ML, 3,000 UNIT/ML, 4,000 UNIT/ML, 40,000 UNIT/ML	1	PA
PROMACTA	1	PA; LA
RETACRIT	1	PA
BLOOD PRODUCTS AND MODIFIERS		
PROMACTA	1	PA; LA
HEMOSTASIS AGENTS		
tranexamic acid oral	1	
PLATELET MODIFYING AGENTS		
aspirin-dipyridamole	1	
BRILINTA	1	
CABLIVI INJECTION KIT	1	PA; LA

Drug Name	Drug Tier	Requirements/ Limits
cilostazol	1	
clopidogrel oral tablet 75 mg	1	QL (30 EA per 30 days)
dipyridamole oral	1	
DOPTELET (10 TAB PACK)	1	PA; LA
DOPTELET (15 TAB PACK)	1	PA; LA
DOPTELET (30 TAB PACK)	1	PA; LA
prasugrel	1	
CARDIOVASCULAR AGENTS		
ALPHA-ADRENERGIC AGONISTS		
clonidine	1	QL (4 EA per 28 days)
clonidine hcl oral tablet	1	
droxidopa	1	PA
midodrine	1	
ALPHA-ADRENERGIC BLOCKING AGENTS		
doxazosin oral tablet 1 mg, 2 mg, 4 mg	1	QL (30 EA per 30 days)
doxazosin oral tablet 8 mg	1	QL (60 EA per 30 days)
prazosin	1	
terazosin oral capsule 1 mg, 2 mg, 5 mg	1	QL (30 EA per 30 days)
terazosin oral capsule 10 mg	1	QL (60 EA per 30 days)
ANGIOTENSIN II RECEPTOR ANTAGONISTS		
candesartan	1	
irbesartan	1	
losartan	1	
olmesartan	1	
telmisartan	1	
valsartan oral tablet	1	
ANGIOTENSIN-CONVERTING ENZYME (ACE) INHIBITORS		
benazepril	1	
captopril	1	
enalapril maleate oral tablet	1	
fosinopril	1	
lisinopril	1	
moexipril	1	
perindopril erbumine	1	
quinapril	1	
ramipril	1	
trandolapril	1	
ANTIARRHYTHMICS		
acebutolol	1	
amiodarone oral	1	
CARTIA XT	1	
digoxin oral	1	
diltiazem hcl oral capsule,extended release 12 hr	1	
diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg	1	
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	1	
diltiazem hcl oral tablet	1	
diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg	1	
DILT-XR	1	
dofetilide	1	

Drug Name	Drug Tier	Requirements/ Limits
flecainide	1	
MATZIM LA	1	
mexiletine	1	
PACERONE ORAL TABLET 100 MG, 200 MG, 400 MG	1	
propafenone	1	
quinidine sulfate oral tablet	1	
SOTALOL AF	1	
sotalol oral	1	
TIADYLT ER	1	
verapamil oral	1	
BETA-ADRENERGIC BLOCKING AGENTS		
acebutolol	1	
atenolol	1	
betaxolol oral	1	
bisoprolol fumarate	1	
carvedilol	1	
labetalol oral	1	
metoprolol succinate	1	
metoprolol tartrate oral	1	
nadolol	1	
nebivolol	1	
pindolol	1	
propranolol oral	1	
timolol maleate oral	1	
CALCIUM CHANNEL BLOCKING AGENTS, DIHYDROPYRIDINES		
amlodipine	1	
felodipine	1	
nicardipine oral	1	

Drug Name	Drug Tier	Requirements/ Limits
nifedipine oral tablet extended release	1	
nifedipine oral tablet extended release 24hr	1	
nimodipine oral capsule	1	
CALCIUM CHANNEL BLOCKING AGENTS, NONDIHYDROPYRIDINES		
CARTIA XT	1	
diltiazem hcl oral capsule,extended release 12 hr	1	
diltiazem hcl oral capsule,extended release 24 hr 360 mg, 420 mg	1	
diltiazem hcl oral capsule,extended release 24hr 120 mg, 180 mg, 240 mg, 300 mg	1	
diltiazem hcl oral tablet	1	
diltiazem hcl oral tablet extended release 24 hr 180 mg, 240 mg, 300 mg, 360 mg	1	
DILT-XR	1	
MATZIM LA	1	
TIADYLT ER	1	
verapamil oral	1	
CARDIOVASCULAR AGENTS, OTHER		
acetazolamide oral tablet	1	
aliskiren	1	
amiloride-hydrochlorothiazide	1	
amlodipine-benazepril	1	
amlodipine-olmesartan	1	

Drug Name	Drug Tier	Requirements/ Limits
amlodipine-valsartan	1	
amlodipine-valsartan-hcthiazid	1	
atenolol-chlorthalidone	1	
benazepril-hydrochlorothiazide	1	
bisoprolol-hydrochlorothiazide	1	
candesartan-hydrochlorothiazid	1	
CORLANOR ORAL SOLUTION	1	QL (450 ML per 30 days)
CORLANOR ORAL TABLET	1	QL (60 EA per 30 days)
digoxin oral	1	
enalapril-hydrochlorothiazide	1	
ENTRESTO	1	QL (60 EA per 30 days)
ENTRESTO SPRINKLE	1	QL (240 EA per 30 days)
fosinopril-hydrochlorothiazide	1	
hydrochlorothiazide oral tablet 25 mg	1	
irbesartan-hydrochlorothiazide	1	
ivabradine	1	QL (60 EA per 30 days)
lisinopril-hydrochlorothiazide	1	
losartan-hydrochlorothiazide	1	
metoprolol ta-hydrochlorothiaz	1	
metyrosine	1	PA
olmesartan-amlodipin-hcthiazid	1	
olmesartan-hydrochlorothiazide	1	
pentoxifylline	1	
ranolazine	1	
spironolacton-hydrochlorothiaz	1	
telmisartan-amlodipine	1	
telmisartan-hydrochlorothiazid	1	
triamterene-hydrochlorothiazid	1	
valsartan-hydrochlorothiazide	1	
DIURETICS, LOOP		
bumetanide	1	
furosemide injection solution	1	
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	1	
furosemide oral tablet	1	
torsemide oral	1	
DIURETICS, POTASSIUM-SPARING		
amiloride	1	
eplerenone	1	
KERENDIA	1	PA; QL (30 EA per 30 days)
spironolactone oral tablet	1	
DIURETICS, THIAZIDE		
chlorthalidone oral tablet 25 mg, 50 mg	1	
hydrochlorothiazide	1	
indapamide	1	
metolazone	1	
DYSLIPIDEMICS, FIBRIC ACID DERIVATIVES		
fenofibrate micronized oral capsule 134 mg, 200 mg, 43 mg, 67 mg	1	

Drug Name	Drug Tier	Requirements/ Limits
fenofibrate nanocrystallized	1	
fenofibrate oral tablet 160 mg, 54 mg	1	
fenofibric acid (choline)	1	
gemfibrozil	1	
DYSLIPIDEMICS, HMG COA REDUCTASE INHIBITORS		
atorvastatin	1	QL (30 EA per 30 days)
fluvastatin oral capsule 20 mg	1	QL (30 EA per 30 days)
fluvastatin oral capsule 40 mg	1	QL (60 EA per 30 days)
lovastatin oral tablet 10 mg	1	QL (30 EA per 30 days)
lovastatin oral tablet 20 mg, 40 mg	1	QL (60 EA per 30 days)
pitavastatin calcium	1	QL (30 EA per 30 days)
pravastatin	1	QL (30 EA per 30 days)
rosuvastatin	1	QL (30 EA per 30 days)
simvastatin	1	QL (30 EA per 30 days)
DYSLIPIDEMICS, OTHER		
cholestyramine (with sugar) oral powder in packet	1	
CHOLESTYRAMINE LIGHT ORAL POWDER IN PACKET	1	
colesevelam	1	
colestipol oral packet	1	
colestipol oral tablet	1	
ezetimibe	1	
ezetimibe-simvastatin	1	QL (30 EA per 30 days)
icosapent ethyl	1	
JUXTAPID	1	PA; LA
niacin oral tablet 500 mg	1	
niacin oral tablet extended release 24 hr	1	
omega-3 acid ethyl esters	1	
PREVALITE ORAL POWDER IN PACKET	1	
REPATHA PUSHTRONEX	1	PA; QL (7 ML per 28 days)
REPATHA SURECLICK	1	PA; QL (6 ML per 28 days)
REPATHA SYRINGE	1	PA; QL (6 ML per 28 days)
VASODILATORS, DIRECT-ACTING ARTERIAL/ VENOUS		
isosorbide dinitrate oral tablet 10 mg, 20 mg, 30 mg, 5 mg	1	
isosorbide mononitrate	1	
NITRO-BID	1	
nitroglycerin rectal	1	
nitroglycerin sublingual	1	
nitroglycerin transdermal patch 24 hour	1	
nitroglycerin translingual	1	
RECTIV	1	
VASODILATORS, DIRECT-ACTING ARTERIAL		
hydralazine oral	1	
minoxidil oral	1	

Drug Name	Drug Tier	Requirements/ Limits
CENTRAL NERVOUS SYSTEM AGENTS		
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, AMPHETAMINES		
dextroamphetamine-amphetamine oral capsule,extended release 24hr	1	
dextroamphetamine-amphetamine oral tablet	1	
ATTENTION DEFICIT HYPERACTIVITY DISORDER AGENTS, NON-AMPHETAMINES		
atomoxetine oral capsule 10 mg, 18 mg, 25 mg, 40 mg	1	QL (60 EA per 30 days)
atomoxetine oral capsule 100 mg, 60 mg, 80 mg	1	QL (30 EA per 30 days)
clonidine hcl oral tablet extended release 12 hr	1	
methylphenidate hcl oral capsule,er biphasic 50-50	1	
methylphenidate hcl oral solution	1	
methylphenidate hcl oral tablet	1	
methylphenidate hcl oral tablet extended release	1	
methylphenidate hcl oral tablet,chewable	1	

Drug Name	Drug Tier	Requirements/ Limits
CENTRAL NERVOUS SYSTEM, OTHER		
FIRDAPSE	1	PA; LA
NUEDEXTA	1	PA
RADICAVA ORS STARTER KIT SUSP	1	
riluzole	1	PA
tetrabenazine oral tablet 12.5 mg	1	PA; QL (240 EA per 30 days)
tetrabenazine oral tablet 25 mg	1	PA; QL (120 EA per 30 days)
FIBROMYALGIA AGENTS		
duloxetine oral capsule,delayed release(dr/ec) 20 mg, 30 mg, 60 mg	1	ST; QL (60 EA per 30 days)
pregabalin oral capsule 100 mg, 150 mg, 200 mg, 25 mg, 50 mg, 75 mg	1	QL (90 EA per 30 days)
pregabalin oral capsule 225 mg, 300 mg	1	QL (60 EA per 30 days)
pregabalin oral solution	1	QL (900 ML per 30 days)
MULTIPLE SCLEROSIS AGENTS		
AVONEX INTRAMUSCULAR PEN INJECTOR KIT	1	PA; QL (1 EA per 28 days)
AVONEX INTRAMUSCULAR SYRINGE KIT	1	PA; QL (1 EA per 28 days)
BETASERON SUBCUTANEOUS KIT	1	PA; QL (14 EA per 28 days)
dalfampridine	1	PA; QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg	1	PA; QL (14 EA per 30 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 120 mg (14)- 240 mg (46)	1	PA; QL (120 EA per 180 days)
dimethyl fumarate oral capsule,delayed release(dr/ec) 240 mg	1	PA; QL (60 EA per 30 days)
fingolimod	1	PA; QL (30 EA per 30 days)
glatiramer subcutaneous syringe 20 mg/ml	1	PA; QL (30 ML per 30 days)
glatiramer subcutaneous syringe 40 mg/ml	1	PA; QL (12 ML per 28 days)
GLATOPA SUBCUTANEOUS SYRINGE 20 MG/ML	1	PA; QL (30 ML per 30 days)
GLATOPA SUBCUTANEOUS SYRINGE 40 MG/ML	1	PA; QL (12 ML per 28 days)
KESIMPTA PEN	1	PA; QL (1.6 ML per 28 days)
DENTAL AND ORAL AGENTS		
DENTAL AND ORAL AGENTS		
chlorhexidine gluconate mucous membrane	1	
KOURZEQ	1	QL (90 GM per 30 days)
PERIOGARD	1	
pilocarpine hcl oral	1	
triamcinolone acetonide dental	1	

Drug Name	Drug Tier	Requirements/ Limits
DERMATOLOGICAL AGENTS		
ACNE AND ROSACEA AGENTS		
ACCUTANE ORAL CAPSULE 10 MG, 20 MG, 40 MG	1	
acitretin	1	
AMNESTEEM	1	
CLARAVIS	1	
isotretinoin	1	
ivermectin topical cream	1	QL (90 GM per 30 days)
tazarotene topical cream	1	PA
tazarotene topical gel	1	PA
tretinoin	1	PA
ZENATANE	1	
DERMATITIS AND PRURITUS AGENTS		
ALA-CORT TOPICAL CREAM 1 %	1	
alclometasone	1	
ammonium lactate	1	
betamethasone dipropionate	1	
betamethasone valerate topical cream	1	
betamethasone valerate topical lotion	1	
betamethasone valerate topical ointment	1	
betamethasone, augmented	1	
clobetasol scalp	1	QL (100 ML per 28 days)
clobetasol topical cream	1	QL (120 GM per 28 days)
clobetasol topical foam	1	QL (100 GM per 28 days)

Drug Name	Drug Tier	Requirements/ Limits
clobetasol topical gel	1	QL (120 GM per 28 days)
clobetasol topical lotion	1	QL (118 ML per 28 days)
clobetasol topical ointment	1	QL (120 GM per 28 days)
clobetasol topical shampoo	1	QL (236 ML per 28 days)
clobetasol-emollient topical cream	1	QL (120 GM per 28 days)
CLODAN	1	QL (236 ML per 28 days)
desonide	1	
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	1	PA; QL (4.56 ML per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	1	PA; QL (8 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	1	PA; QL (4.56 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	1	PA; QL (8 ML per 28 days)
fluocinolone and shower cap	1	
fluocinolone topical cream	1	
fluocinolone topical ointment	1	
fluocinolone topical solution	1	
fluocinonide topical cream 0.05 %	1	QL (120 GM per 30 days)
fluocinonide topical gel	1	QL (120 GM per 30 days)
fluocinonide topical ointment	1	QL (120 GM per 30 days)
fluocinonide topical solution	1	QL (120 ML per 30 days)
fluocinonide-emollient	1	QL (120 GM per 30 days)
halobetasol propionate topical cream	1	
halobetasol propionate topical ointment	1	
hydrocortisone topical cream 1 %	1	
hydrocortisone topical cream with perineal applicator 2.5 %	1	
hydrocortisone topical lotion 2.5 %	1	
hydrocortisone topical ointment 1 %, 2.5 %	1	
mometasone topical	1	
pimecrolimus	1	PA; QL (100 GM per 30 days)
PROCTO-MED HC	1	
PROCTOSOL HC TOPICAL	1	
PROCTOZONE-HC	1	
selenium sulfide topical lotion	1	
tacrolimus topical	1	PA; QL (100 GM per 30 days)
triamcinolone acetonide topical cream	1	
triamcinolone acetonide topical lotion	1	
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	1	
TRIDERM TOPICAL CREAM	1	
DERMATOLOGICAL AGENTS, OTHER		
ALCOHOL PADS	1	

Drug Name	Drug Tier	Requirements/ Limits
calcipotriene scalp	1	QL (120 ML per 30 days)
calcipotriene topical cream	1	QL (120 GM per 30 days)
calcipotriene topical ointment	1	QL (120 GM per 30 days)
clotrimazole-betamethasone topical cream	1	QL (45 GM per 28 days)
clotrimazole-betamethasone topical lotion	1	QL (60 ML per 28 days)
fluorouracil topical cream 5 %	1	
fluorouracil topical solution	1	
imiquimod topical cream in packet 5 %	1	
methoxsalen	1	
nystatin-triamcinolone	1	QL (60 GM per 28 days)
OTEZLA	1	PA; QL (60 EA per 30 days)
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51)	1	PA; QL (55 EA per 180 days)
PANRETIN	1	PAns
podofilox topical solution	1	
REGRANEX	1	QL (15 GM per 30 days)
SANTYL	1	QL (180 GM per 30 days)
silver sulfadiazine	1	
SSD	1	
DERMATOLOGICAL AGENTS		
ACCUTANE ORAL CAPSULE 20 MG, 40 MG	1	

Drug Name	Drug Tier	Requirements/ Limits
PEDICULICIDES/SCABICIDES		
CROTAN	1	
ivermectin topical cream	1	QL (90 GM per 30 days)
malathion	1	
permethrin	1	QL (60 GM per 30 days)
TOPICAL ANTI-INFECTIVES		
acyclovir topical ointment	1	PA; QL (30 GM per 30 days)
ciclopirox topical gel	1	QL (100 GM per 28 days)
ciclopirox topical shampoo	1	QL (120 ML per 28 days)
ciclopirox topical solution	1	QL (6.6 ML per 28 days)
clindamycin phosphate topical gel	1	QL (120 GM per 30 days)
clindamycin phosphate topical gel, once daily	1	QL (150 ML per 30 days)
clindamycin phosphate topical lotion	1	QL (120 ML per 30 days)
clindamycin phosphate topical solution	1	QL (120 ML per 30 days)
ERY PADS	1	
erythromycin with ethanol topical solution	1	
mupirocin	1	QL (44 GM per 30 days)
penciclovir	1	QL (5 GM per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
ELECTROLYTES/MINERALS/METALS/VITAMINS		
ELECTROLYTE/ MINERAL REPLACEMENT		
carglumic acid	1	PA
ISOLYTE S PH 7.4	1	
KLOR-CON 10	1	
KLOR-CON 8	1	
KLOR-CON M10	1	
KLOR-CON M15	1	
KLOR-CON M20	1	
magnesium sulfate injection	1	
PLASMA-LYTE A	1	
potassium chlorid-d5-0.45%nacl	1	
potassium chloride in 0.9%nacl intravenous parenteral solution 20 meq/l, 40 meq/l	1	
potassium chloride in 5 % dex intravenous parenteral solution 20 meq/l	1	
potassium chloride in lr-d5 intravenous parenteral solution 20 meq/l	1	
potassium chloride in water intravenous piggyback 10 meq/100 ml, 20 meq/100 ml, 40 meq/100 ml	1	
potassium chloride intravenous solution 2 meq/ml	1	
potassium chloride oral capsule, extended release	1	
potassium chloride oral liquid	1	
potassium chloride oral packet	1	
potassium chloride oral tablet extended release 10 meq, 20 meq, 8 meq	1	
potassium chloride oral tablet,er particles/crystals	1	
potassium chloride-0.45 % nacl	1	
potassium chloride-d5-0.2%nacl intravenous parenteral solution 20 meq/l	1	
potassium chloride-d5-0.9%nacl	1	
potassium citrate oral tablet extended release	1	
sodium chloride 0.45 % intravenous	1	
sodium chloride 0.9 % intravenous parenteral solution	1	
sodium chloride 3 % hypertonic	1	
sodium chloride 5 % hypertonic	1	
sodium chloride irrigation	1	
sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram	1	
ELECTROLYTE/MINERAL/METAL MODIFIERS		
CHEMET	1	PA
deferasirox oral tablet	1	PA
deferiprone	1	PA
KLOR-CON	1	
penicillamine oral tablet	1	PA

Drug Name	Drug Tier	Requirements/ Limits
potassium chloride oral tablet,er particles/crystals 15 meq	1	
tolvaptan	1	PA
trientine oral capsule 250 mg	1	PA
ELECTROLYTES/ MINERALS/METALS/VITAMINS		
CLINIMIX 5%/D15W SULFITE FREE	1	BvD
CLINIMIX 4.25%/D10W SULF FREE	1	BvD
CLINIMIX 4.25%/D5W SULFIT FREE	1	BvD
CLINIMIX 5%-D20W(SULFITE-FREE)	1	BvD
d10 %-0.45 % sodium chloride	1	
d2.5 %-0.45 % sodium chloride	1	
d5 % and 0.9 % sodium chloride	1	
d5 %-0.45 % sodium chloride	1	
dextrose 10 % and 0.2 % nacl	1	
dextrose 10 % in water (d10w)	1	
dextrose 5 % in water (d5w) intravenous piggyback	1	
dextrose 5%-0.2 % sod chloride	1	
INTRALIPID INTRAVENOUS EMULSION 20 %	1	BvD
ISOLYTE-P IN 5 % DEXTROSE	1	

Drug Name	Drug Tier	Requirements/ Limits
levocarnitine (with sugar)	1	
levocarnitine oral tablet	1	
PREMASOL 10 %	1	BvD
TRAVASOL 10 %	1	BvD
TROPHAMINE 10 %	1	BvD
PHOSPHATE BINDERS		
calcium acetate(phosphat bind)	1	QL (360 EA per 30 days)
sevelamer carbonate oral tablet	1	QL (270 EA per 30 days)
POTASSIUM BINDERS		
KIONEX (WITH SORBITOL)	1	
LOKELMA	1	
sodium polystyrene sulfonate oral powder	1	
SPS (WITH SORBITOL) ORAL	1	
VITAMINS		
KLOR-CON	1	
KLOR-CON 10	1	
KLOR-CON 8	1	
KLOR-CON M10	1	
KLOR-CON M15	1	
KLOR-CON M20	1	
potassium chloride oral tablet,er particles/crystals 15 meq	1	
PRENATAL VITAMIN PLUS LOW IRON	1	
GASTROINTESTINAL AGENTS		
ANTI-CONSTIPATION AGENTS		
CONSTULOSE	1	

Drug Name	Drug Tier	Requirements/ Limits
ENULOSE	1	
GAVILYTE-C	1	
GAVILYTE-G	1	
GAVILYTE-N	1	
lactulose oral solution 10 gram/15 ml	1	
lubiprostone	1	QL (60 EA per 30 days)
MOVANTIK	1	QL (30 EA per 30 days)
peg 3350-electrolytes	1	
peg3350-sod sul-nacl-kcl-asb-c	1	
peg-electrolyte soln	1	
RELISTOR SUBCUTANEOUS SOLUTION	1	QL (18 ML per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 12 MG/0.6 ML	1	QL (18 ML per 30 days)
RELISTOR SUBCUTANEOUS SYRINGE 8 MG/0.4 ML	1	QL (12 ML per 30 days)
sodium,potassium,mag sulfates oral recon soln 17.5-3.13-1.6 gram	1	
TRULANCE	1	
ANTI-DIARRHEAL AGENTS		
alosetron	1	PA
diphenoxylate-atropine	1	
loperamide oral capsule	1	
XERMELO	1	PA; LA; QL (84 EA per 28 days)
XIFAXAN ORAL TABLET 200 MG	1	QL (9 EA per 30 days)
XIFAXAN ORAL TABLET 550 MG	1	QL (90 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
ANTISPASMODICS, GASTROINTESTINAL		
dicyclomine oral capsule	1	
dicyclomine oral solution	1	
dicyclomine oral tablet	1	
glycopyrrolate oral tablet	1	
scopolamine base	1	
GASTROINTESTINAL AGENTS, OTHER		
CHENODAL	1	PA; LA
GATTEX 30-VIAL	1	PA
GAVILYTE-N	1	
metoclopramide hcl oral solution	1	
metoclopramide hcl oral tablet	1	
MYALEPT	1	PA; LA
OCALIVA	1	PA; LA; QL (30 EA per 30 days)
REZDIFFRA	1	PA; QL (30 EA per 30 days)
ursodiol oral capsule 300 mg	1	
ursodiol oral tablet	1	
XIFAXAN ORAL TABLET 550 MG	1	QL (90 EA per 30 days)
HISTAMINE2 (H2) RECEPTOR ANTAGONISTS		
famotidine oral tablet 20 mg, 40 mg	1	
PROTECTANTS		
misoprostol	1	
sucralfate	1	

Drug Name	Drug Tier	Requirements/ Limits
PROTON PUMP INHIBITORS		
esomeprazole magnesium oral capsule,delayed release(dr/ec) 20 mg	1	QL (30 EA per 30 days)
esomeprazole magnesium oral capsule,delayed release(dr/ec) 40 mg	1	
lansoprazole oral capsule,delayed release(dr/ec) 15 mg	1	QL (30 EA per 30 days)
lansoprazole oral capsule,delayed release(dr/ec) 30 mg	1	
omeprazole oral capsule,delayed release(dr/ec) 10 mg, 20 mg	1	QL (30 EA per 30 days)
omeprazole oral capsule,delayed release(dr/ec) 40 mg	1	QL (60 EA per 30 days)
pantoprazole oral tablet,delayed release (dr/ec) 20 mg	1	QL (30 EA per 30 days)
pantoprazole oral tablet,delayed release (dr/ec) 40 mg	1	
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
GENETIC OR ENZYME OR PROTEIN DISORDER: REPLACEMENT, MODIFIERS, TREATMENT		
betaine	1	
CHOLBAM ORAL CAPSULE 250 MG	1	PA
CHOLBAM ORAL CAPSULE 50 MG	1	PA; QL (120 EA per 30 days)
CREON	1	
cromolyn inhalation	1	BvD
cromolyn oral	1	
CYSTAGON	1	PA; LA
FIRDAPSE	1	PA; LA
glutamine (sickle cell)	1	PA
nitisinone oral capsule 10 mg, 2 mg, 5 mg	1	PA
PLENAMINE	1	BvD
sapropterin	1	PA
sodium phenylbutyrate	1	PA
SUCRAID	1	PA
VIOKACE	1	
GENITOURINARY AGENTS		
ANTISPASMODICS, URINARY		
mirabegron	1	
MYRBETRIQ	1	
oxybutynin chloride oral syrup	1	
oxybutynin chloride oral tablet 5 mg	1	
oxybutynin chloride oral tablet extended release 24hr	1	
tolterodine	1	
trospium oral tablet	1	
BENIGN PROSTATIC HYPERTROPHY AGENTS		
alfuzosin	1	
doxazosin oral tablet 1 mg, 2 mg, 4 mg	1	QL (30 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
doxazosin oral tablet 8 mg	1	QL (60 EA per 30 days)
dutasteride	1	
finasteride oral tablet 5 mg	1	
prazosin	1	
tamsulosin	1	
terazosin oral capsule 1 mg, 2 mg, 5 mg	1	QL (30 EA per 30 days)
terazosin oral capsule 10 mg	1	QL (60 EA per 30 days)
GENITOURINARY AGENTS, OTHER		
bethanechol chloride	1	
ELMIRON	1	
penicillamine oral tablet	1	PA
HORMONAL AGENTS, STIMULANT/ REPLACEMENT / MODIFYING (ADRENAL)		
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (ADRENAL)		
betamethasone dipropionate topical ointment	1	
betamethasone, augmented topical cream	1	
budesonide oral	1	
dexamethasone oral solution	1	
dexamethasone oral tablet	1	
fludrocortisone	1	
hydrocortisone oral	1	

Drug Name	Drug Tier	Requirements/ Limits
methylprednisolone oral tablet	1	BvD
methylprednisolone oral tablets,dose pack	1	
prednisolone oral solution	1	
prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	1	
PREDNISONE INTENSOL	1	
prednisone oral solution	1	
prednisone oral tablet	1	
prednisone oral tablets,dose pack 10 mg, 5 mg	1	
TRIDERM TOPICAL CREAM 0.5 %	1	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT / MODIFYING (PITUITARY)		
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PITUITARY)		
desmopressin nasal spray,non-aerosol 10 mcg/spray (0.1 ml)	1	
desmopressin oral	1	
INCRELEX	1	LA
OMNITROPE	1	PA
VYNDAMAX	1	PA

Drug Name	Drug Tier	Requirements/ Limits
HORMONAL AGENTS, STIMULANT/ REPLACEMENT / MODIFYING (PROSTAGLANDINS)		
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (PROSTAGLANDINS)		
misoprostol oral tablet 200 mcg	1	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT / MODIFYING (SEX HORMONES/ MODIFIERS)		
ANDROGENS		
danazol	1	
testosterone cypionate intramuscular oil 100 mg/ml, 200 mg/ml	1	PA
testosterone enanthate	1	PAns
testosterone transdermal gel in metered-dose pump 10 mg/0.5 gram /actuation	1	PA; QL (120 GM per 30 days)
testosterone transdermal gel in metered-dose pump 12.5 mg/ 1.25 gram (1 %)	1	PA; QL (300 GM per 30 days)
testosterone transdermal gel in metered-dose pump 20.25 mg/1.25 gram (1.62 %)	1	PA; QL (150 GM per 30 days)
testosterone transdermal gel in packet 1 % (25 mg/2.5gram), 1 % (50 mg/5 gram)	1	PA; QL (300 GM per 30 days)
testosterone transdermal gel in packet 1.62 % (20.25 mg/1.25 gram)	1	PA; QL (37.5 GM per 30 days)
testosterone transdermal gel in packet 1.62 % (40.5 mg/2.5 gram)	1	PA; QL (150 GM per 30 days)
testosterone transdermal solution in metered pump w/app	1	PA; QL (180 ML per 30 days)
ESTROGENS		
DOTTI	1	PA; QL (8 EA per 28 days)
estradiol oral	1	PA
estradiol transdermal patch semiweekly	1	PA; QL (8 EA per 28 days)
estradiol transdermal patch weekly	1	PA; QL (4 EA per 28 days)
estradiol vaginal	1	
estradiol valerate	1	
LYLLANA	1	PA; QL (8 EA per 28 days)
MENEST	1	PA
MYFEMBREE	1	PA
YUVAFEM	1	

Drug Name	Drug Tier	Requirements/ Limits
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (SEX HORMONES/ MODIFIERS)		
ALTAVERA (28)	1	
ALYACEN 1/35 (28)	1	
APRI	1	
ARANELLE (28)	1	
AUBRA EQ	1	
AVIANE	1	
AZURETTE (28)	1	
CRYSELLE (28)	1	
CYRED EQ	1	
desog-e.estradiol/e.estradiol	1	
drospirenone-ethinyl estradiol	1	
ELURYNG	1	
ENPRESSE	1	
ENSKYCE	1	
ESTARYLLA	1	
estradiol-norethindrone acet	1	PA
ethynodiol diac-eth estradiol	1	
etonogestrel-ethinyl estradiol	1	
FALMINA (28)	1	
FYAVOLV	1	PA
INCASSIA	1	
ISIBLOOM	1	
JASMIEL (28)	1	
JINTELI	1	PA
JULEBER	1	
KARIVA (28)	1	
KELNOR 1/35 (28)	1	
KELNOR 1/50 (28)	1	

Drug Name	Drug Tier	Requirements/ Limits
KURVELO (28)	1	
l norgest/e.estradiol-e.estrad oral tablets,dose pack,3 month 0.1 mg-20 mcg (84)/10 mcg (7)	1	
LARIN 1.5/30 (21)	1	
LARIN 1/20 (21)	1	
LARIN FE 1.5/30 (28)	1	
LARIN FE 1/20 (28)	1	
LESSINA	1	
LEVONEST (28)	1	
levonorgestrel-ethinyl estrad oral tablet 0.1-20 mg-mcg, 0.15-0.03 mg	1	
levonorgestrel-ethinyl estrad oral tablets,dose pack,3 month	1	
levonorg-eth estrad triphasic	1	
LEVORA-28	1	
LORYNA (28)	1	
LOW-OGESTREL (28)	1	
LUTERA (28)	1	
MARLISSA (28)	1	
MICROGESTIN 1.5/30 (21)	1	
MICROGESTIN 1/20 (21)	1	
MICROGESTIN FE 1.5/30 (28)	1	
MICROGESTIN FE 1/20 (28)	1	
MILI	1	
MIMVEY	1	PA
NIKKI (28)	1	
norelgestromin-ethin.estradiol	1	
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	PA

Drug Name	Drug Tier	Requirements/ Limits
norethindrone ac-eth estradiol oral tablet 1-20 mg-mcg	1	
norethindrone-e.estradiol-iron oral tablet 1 mg-20 mcg (21)/75 mg (7)	1	
norgestimate-ethinyl estradiol	1	
NORTREL 0.5/35 (28)	1	
NORTREL 1/35 (21)	1	
NORTREL 1/35 (28)	1	
NORTREL 7/7/7 (28)	1	
PIMTREA (28)	1	
PORTIA 28	1	
RECLIPSEN (28)	1	
SETLAKIN	1	
SHAROBEL	1	
SPRINTEC (28)	1	
SRONYX	1	
SYEDA	1	
TARINA FE 1-20 EQ (28)	1	
TILIA FE	1	
TRI-ESTARYLLA	1	
TRI-LEGEST FE	1	
TRI-LO-ESTARYLLA	1	
TRI-LO-SPRINTEC	1	
TRI-SPRINTEC (28)	1	
TRIVORA (28)	1	
TURQOZ (28)	1	
VELIVET TRIPHASIC REGIMEN (28)	1	
VESTURA (28)	1	
VIENVA	1	
XULANE	1	
ZAFEMY	1	
ZOVIA 1-35 (28)	1	

Drug Name	Drug Tier	Requirements/ Limits
PROGESTINS		
CAMILA	1	
DEBLITANE	1	
ERRIN	1	
HEATHER	1	
INCASSIA	1	
LYLEQ	1	
LYZA	1	
medroxyprogesterone	1	
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml (125 mg/ml)	1	PA
megestrol oral tablet	1	PAns
NORA-BE	1	
norethindrone (contraceptive)	1	
norethindrone acetate	1	
progesterone micronized	1	
SHAROBEL	1	
SELECTIVE ESTROGEN RECEPTOR MODIFYING AGENTS		
raloxifene	1	
HORMONAL AGENTS, STIMULANT/ REPLACEMENT / MODIFYING (THYROID)		
HORMONAL AGENTS, STIMULANT/ REPLACEMENT/ MODIFYING (THYROID)		
EUTHYROX	1	

Drug Name	Drug Tier	Requirements/ Limits
levothyroxine oral tablet	1	
LEVOXYL ORAL TABLET 100 MCG, 112 MCG, 125 MCG, 137 MCG, 150 MCG, 175 MCG, 200 MCG, 25 MCG, 50 MCG, 75 MCG, 88 MCG	1	
liothyronine oral	1	
UNITHROID	1	
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
HORMONAL AGENTS, SUPPRESSANT (ADRENAL)		
LYSODREN	1	
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
HORMONAL AGENTS, SUPPRESSANT (PITUITARY)		
bromocriptine	1	
cabergoline	1	
ELIGARD	1	PAns
ELIGARD (3 MONTH)	1	PAns
ELIGARD (4 MONTH)	1	PAns
ELIGARD (6 MONTH)	1	PAns
FIRMAGON KIT W DILUENT SYRINGE	1	PAns
leuprolide subcutaneous kit	1	PAns
octreotide acetate injection solution	1	PA
SIGNIFOR	1	PA
SOMAVERT	1	PA

Drug Name	Drug Tier	Requirements/ Limits
HORMONAL AGENTS, SUPPRESSANT (THYROID)		
ANTITHYROID AGENTS		
methimazole oral tablet 10 mg, 5 mg	1	
propylthiouracil	1	
IMMUNOLOGICAL AGENTS		
ANGIOEDEMA AGENTS		
CINRYZE	1	PA
icatibant	1	PA
SAJAZIR	1	PA
IMMUNOGLOBULINS		
BIVIGAM	1	
PRIVIGEN	1	PA
IMMUNOLOGICAL AGENTS, OTHER		
ARCALYST	1	PA
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 200 MG/1.14 ML	1	PA; QL (4.56 ML per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	1	PA; QL (8 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	1	PA; QL (4.56 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	1	PA; QL (8 ML per 28 days)
leflunomide	1	QL (30 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
ORENCIA CLICKJECT	1	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 125 MG/ML	1	PA; QL (4 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 50 MG/0.4 ML	1	PA; QL (1.6 ML per 28 days)
ORENCIA SUBCUTANEOUS SYRINGE 87.5 MG/0.7 ML	1	PA; QL (2.8 ML per 28 days)
REVCOVI	1	PA; LA
RIDAURA	1	
RINVOQ LQ	1	PA; QL (360 ML per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 15 MG, 30 MG	1	PA; QL (30 EA per 30 days)
RINVOQ ORAL TABLET EXTENDED RELEASE 24 HR 45 MG	1	PA; QL (56 EA per 180 days)
SKYRIZI SUBCUTANEOUS PEN INJECTOR	1	PA; QL (2 ML per 28 days)
SKYRIZI SUBCUTANEOUS SYRINGE 150 MG/ML	1	PA; QL (2 ML per 28 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 180 MG/1.2 ML (150 MG/ML)	1	PA; QL (1.2 ML per 56 days)
SKYRIZI SUBCUTANEOUS WEARABLE INJECTOR 360 MG/2.4 ML (150 MG/ML)	1	PA; QL (2.4 ML per 56 days)
STELARA SUBCUTANEOUS SOLUTION	1	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SYRINGE 45 MG/0.5 ML	1	PA; QL (0.5 ML per 28 days)
STELARA SUBCUTANEOUS SYRINGE 90 MG/ML	1	PA; QL (1 ML per 28 days)
TALTZ AUTOINJECTOR	1	PA; QL (1 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 20 MG/0.25 ML	1	PA; QL (0.25 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 40 MG/0.5 ML	1	PA; QL (0.5 ML per 28 days)
TALTZ SYRINGE SUBCUTANEOUS SYRINGE 80 MG/ML	1	PA; QL (1 ML per 28 days)
XELJANZ ORAL SOLUTION	1	PA; QL (480 ML per 24 days)
XELJANZ ORAL TABLET	1	PA; QL (60 EA per 30 days)
XELJANZ XR	1	PA; QL (30 EA per 30 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 150 MG/ML, 300 MG/2 ML	1	PA; LA; QL (8 ML per 28 days)
XOLAIR SUBCUTANEOUS AUTO-INJECTOR 75 MG/0.5 ML	1	PA; LA; QL (1 ML per 28 days)
XOLAIR SUBCUTANEOUS RECON SOLN	1	PA; LA; QL (8 EA per 28 days)
XOLAIR SUBCUTANEOUS SYRINGE 150 MG/ML, 300 MG/2 ML	1	PA; LA; QL (8 ML per 28 days)

Drug Name	Drug Tier	Requirements/ Limits
XOLAIR SUBCUTANEOUS SYRINGE 75 MG/0.5 ML	1	PA; LA; QL (1 ML per 28 days)
IMMUNOSTIMULANTS		
ACTIMMUNE	1	BvD
BESREMI	1	PAns; LA
PEGASYS SUBCUTANEOUS SOLUTION	1	QL (4 ML per 28 days)
PEGASYS SUBCUTANEOUS SYRINGE	1	QL (2 ML per 28 days)
IMMUNOSUPPRESSANTS		
ACTEMRA ACTPEN	1	PA; QL (3.6 ML per 28 days)
ACTEMRA SUBCUTANEOUS	1	PA; QL (3.6 ML per 28 days)
adalimumab-adaz	1	PA; QL (1.6 ML per 28 days)
adalimumab-adbm subcutaneous pen injector kit	1	PA; QL (4 EA per 28 days)
adalimumab-adbm subcutaneous syringe kit 10 mg/0.2 ml, 20 mg/0.4 ml	1	PA; QL (2 EA per 28 days)
adalimumab-adbm subcutaneous syringe kit 40 mg/0.4 ml, 40 mg/0.8 ml	1	PA; QL (4 EA per 28 days)
ADALIMUMAB-ADBM(CF) PEN CROHNS	1	PA; QL (6 EA per 180 days)
ADALIMUMAB-ADBM(CF) PEN PS-UV	1	PA; QL (4 EA per 180 days)
azathioprine oral tablet 50 mg	1	BvD

Drug Name	Drug Tier	Requirements/ Limits
BENLYSTA SUBCUTANEOUS	1	PA
cyclosporine modified	1	BvD
cyclosporine ophthalmic (eye)	1	QL (60 EA per 30 days)
cyclosporine oral capsule	1	BvD
CYLTEZO(CF) PEN	1	PA; QL (4 EA per 28 days)
CYLTEZO(CF) PEN CROHN'S-UC-HS	1	PA; QL (6 EA per 180 days)
CYLTEZO(CF) PEN PSORIASIS-UV	1	PA; QL (4 EA per 180 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.2 ML, 20 MG/0.4 ML	1	PA; QL (2 EA per 28 days)
CYLTEZO(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML, 40 MG/0.8 ML	1	PA; QL (4 EA per 28 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	1	PA; QL (8 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	1	PA; QL (4.56 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	1	PA; QL (8 ML per 28 days)
ENBREL MINI	1	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SOLUTION	1	PA; QL (8 ML per 28 days)
ENBREL SUBCUTANEOUS SYRINGE	1	PA; QL (8 ML per 28 days)
ENBREL SURECLICK	1	PA; QL (8 ML per 28 days)

Drug Name	Drug Tier	Requirements/ Limits
everolimus (antineoplastic) oral tablet	1	PAns; QL (30 EA per 30 days)
everolimus (antineoplastic) oral tablet for suspension 2 mg	1	PAns; QL (330 EA per 30 days)
everolimus (antineoplastic) oral tablet for suspension 3 mg	1	PAns; QL (240 EA per 30 days)
everolimus (antineoplastic) oral tablet for suspension 5 mg	1	PAns; QL (180 EA per 30 days)
everolimus (immunosuppressive)	1	BvD
GENGRAF	1	BvD
HUMIRA PEN	1	PA; QL (4 EA per 28 days)
HUMIRA SUBCUTANEOUS SYRINGE KIT 40 MG/0.8 ML	1	PA; QL (4 EA per 28 days)
HUMIRA(CF) PEN CROHNS-UC-HS	1	PA; QL (3 EA per 180 days)
HUMIRA(CF) PEN PEDIATRIC UC	1	PA; QL (4 EA per 180 days)
HUMIRA(CF) PEN PSOR-UV-ADOL HS	1	PA; QL (3 EA per 180 days)
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 40 MG/0.4 ML	1	PA; QL (4 EA per 28 days)
HUMIRA(CF) PEN SUBCUTANEOUS PEN INJECTOR KIT 80 MG/0.8 ML	1	PA; QL (2 EA per 28 days)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 10 MG/0.1 ML, 20 MG/0.2 ML	1	PA; QL (2 EA per 28 days)
HUMIRA(CF) SUBCUTANEOUS SYRINGE KIT 40 MG/0.4 ML	1	PA; QL (4 EA per 28 days)
HYRIMOZ PEN CROHN'S-UC STARTER	1	PA; QL (2.4 ML per 180 days)
HYRIMOZ PEN PSORIASIS STARTER	1	PA; QL (1.6 ML per 180 days)
HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML	1	PA; QL (2.4 ML per 180 days)
HYRIMOZ(CF) PEDI CROHN STARTER SUBCUTANEOUS SYRINGE 80 MG/0.8 ML- 40 MG/0.4 ML	1	PA; QL (1.2 ML per 180 days)
HYRIMOZ(CF) PEN	1	PA; QL (1.6 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 10 MG/0.1 ML	1	PA; QL (0.2 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 20 MG/0.2 ML	1	PA; QL (0.4 ML per 28 days)
HYRIMOZ(CF) SUBCUTANEOUS SYRINGE 40 MG/0.4 ML	1	PA; QL (1.6 ML per 28 days)
mercaptopurine	1	
methotrexate sodium	1	BvD
methotrexate sodium (pf) injection solution	1	BvD
mycophenolate mofetil	1	BvD
mycophenolate sodium	1	BvD
MYHIBBIN	1	
OTEZLA ORAL TABLET 20 MG	1	PA; QL (60 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
OTEZLA STARTER ORAL TABLETS,DOSE PACK 10 MG (4)- 20 MG (51), 10 MG (4)-20 MG (4)-30 MG (47)	1	PA; QL (55 EA per 180 days)
PROGRAF ORAL GRANULES IN PACKET	1	BvD
SIMLANDI(CF) AUTOINJECTOR	1	PA; QL (6 EA per 28 days)
sirolimus	1	BvD
tacrolimus oral capsule	1	BvD
TORPENZ	1	PAns; QL (30 EA per 30 days)
TYENNE AUTOINJECTOR	1	PA; QL (3.6 ML per 28 days)
TYENNE SUBCUTANEOUS	1	PA; QL (3.6 ML per 28 days)
XATMEP	1	BvD
XELJANZ XR ORAL TABLET EXTENDED RELEASE 24 HR 22 MG	1	PA; QL (30 EA per 30 days)
ZYMFENTRA	1	PA; QL (2 EA per 28 days)
VACCINES		
ABRYSVO (PF)	1	
ACTHIB (PF)	1	
ADACEL(TDAP ADOLESN/ADULT)(PF)	1	
AREXVY (PF)	1	
bcg vaccine, live (pf)	1	
BEXSERO	1	
BOOSTRIX TDAP INTRAMUSCULAR SYRINGE	1	
DAPTACEL (DTAP PEDIATRIC) (PF)	1	

Drug Name	Drug Tier	Requirements/ Limits
ENGERIX-B (PF)	1	BvD
ENGERIX-B PEDIATRIC (PF)	1	BvD
GARDASIL 9 (PF)	1	
HAVRIX (PF)	1	
HEPLISAV-B (PF)	1	BvD
HIBERIX (PF)	1	
IMOVAX RABIES VACCINE (PF)	1	
INFANRIX (DTAP) (PF)	1	
IPOL	1	
IXCHIQ (PF)	1	
IXIARO (PF)	1	
JYNNEOS (PF)	1	BvD
KINRIX (PF)	1	
MENQUADFI (PF)	1	
MENVEO A-C-Y-W-135-DIP (PF) INTRAMUSCULAR KIT	1	
M-M-R II (PF)	1	
MRESVIA (PF)	1	
PEDIARIX (PF)	1	
PEDVAX HIB (PF)	1	
PENBRAYA (PF)	1	
PENTACEL (PF) INTRAMUSCULAR KIT 15LF-48MCG-62DU -10 MCG/0.5ML	1	
PREHEVBRIO (PF)	1	BvD
PRIORIX (PF)	1	
PROQUAD (PF)	1	
QUADRACEL (PF) INTRAMUSCULAR SUSPENSION 15 LF-48 MCG- 5 LF UNIT/0.5ML	1	
QUADRACEL (PF) INTRAMUSCULAR SYRINGE	1	

Drug Name	Drug Tier	Requirements/ Limits
RABAVERT (PF)	1	
RECOMBIVAX HB (PF)	1	BvD
ROTATEQ VACCINE	1	
SHINGRIX (PF)	1	QL (2 EA per 720 days)
TDVAX	1	
TENIVAC (PF)	1	
TICOVAC	1	
TRUMENBA	1	
TWINRIX (PF)	1	
TYPHIM VI	1	
VAQTA (PF)	1	
VARIVAX (PF)	1	
VAXCHORA VACCINE	1	
YF-VAX (PF) SUBCUTANEOUS SUSPENSION FOR RECONSTITUTION 10 EXP4.74 UNIT/0.5 ML	1	
INFLAMMATORY BOWEL DISEASE AGENTS		
AMINOSALICYLATES		
balsalazide	1	
mesalamine	1	
PENTASA ORAL CAPSULE, EXTENDED RELEASE 250 MG	1	
sulfasalazine	1	
GLUCOCORTICOIDS		
budesonide oral	1	
dexamethasone oral solution	1	
dexamethasone oral tablet	1	
hydrocortisone oral	1	
hydrocortisone rectal	1	
methylprednisolone oral tablet	1	BvD
methylprednisolone oral tablets,dose pack	1	
prednisolone oral solution	1	
prednisolone sodium phosphate oral solution 25 mg/5 ml (5 mg/ml), 5 mg base/5 ml (6.7 mg/5 ml)	1	
PREDNISONE INTENSOL	1	
prednisone oral solution	1	
prednisone oral tablet	1	
prednisone oral tablets,dose pack 10 mg, 5 mg	1	
PROCTO-MED HC	1	
PROCTOZONE-HC	1	
METABOLIC BONE DISEASE AGENTS		
METABOLIC BONE DISEASE AGENTS		
alendronate oral tablet 10 mg	1	QL (30 EA per 30 days)
alendronate oral tablet 35 mg, 70 mg	1	QL (4 EA per 28 days)
calcitonin (salmon) nasal	1	
calcitriol oral	1	
cinacalcet	1	PA
doxercalciferol oral	1	
ibandronate oral	1	QL (1 EA per 30 days)
paricalcitol oral	1	

Drug Name	Drug Tier	Requirements/ Limits
PROLIA	1	PA; QL (1 ML per 180 days)
teriparatide subcutaneous pen injector 20 mcg/dose (620mcg/2.48ml)	1	PA; QL (2.48 ML per 28 days)
XGEVA	1	BvD
NON-FRF		
NON-FRF		
2TEK CONTROL (HIGH-NORMAL)	1	
ACCU-CHEK AVIVA CONTROL SOLN	1	
ACCU-CHEK FASTCLIX LANCING DEV	1	
ACCU-CHEK GUIDE GLUCOSE METER	1	
ACCU-CHEK GUIDE L1-L2 CTRL SOL	1	
ACCU-CHEK GUIDE ME GLUCOSE MTR	1	
ACCU-CHEK MULTICLIX LANCET	1	
ACCU-CHEK SMARTVIEW CONTRL SOL	1	
ACCU-CHEK SOFT DEV LANCETS	1	
ACCUTANE ORAL CAPSULE 30 MG	1	
ACCUTREND GLUCOSE CONTROL	1	
ADJUSTABLE LANCING DEVICE	1	
ADVANCED GLUCOSE METER	1	
ADVANCED LANCING DEVICE	1	
ADVOCATE LANCING DEVICE	1	
ADVOCATE REDI-CODE PLUS	1	

Drug Name	Drug Tier	Requirements/ Limits
ADVOCATE REDI-CODE PLUS CTRL L	1	
ADVOCATE REDI-CODE+ CTRL HIGH	1	
AGAMATRIX AMP GLUC MONITOR SYS	1	
AGAMATRIX CONTROL HIGH	1	
AGAMATRIX CONTROL NORM-HI	1	
ALTERNATE SITE LANCING DEVICE	1	
AQUA LANCE LANCING DEVICE	1	
ASSURE 4 CONTROL SOLUTION	1	
ASSURE DOSE NORM-HI CONTROL	1	
ASSURE PLATINUM GLUCOSE METER	1	
ASSURE PRISM CONTROL 1-2 SOLN	1	
ASSURE PRISM MULTI METER	1	
AUTO-LANCET MINI	1	
AUTOLET IMPRESSION LANC DEV	1	
AUTOLET LANCING DEVICE	1	
AVITA TOPICAL CREAM	1	PA
azelastine nasal spray,non-aerosol 205.5 mcg (0.15 %)	1	QL (60 ML per 30 days)
BIOTEL CARE BGM-4 METER	1	
blood glucose contrl hi,normal	1	
blood glucose control, normal	1	
blood-glucose meter	1	

Drug Name	Drug Tier	Requirements/ Limits
BREEZE 2 CONTROL SOLUTION,HIGH	1	
CAREONE LANCING DEVICE	1	
CARESENS N	1	
CARESENS N VOICE	1	
CARETOUCH CONTROL SOLN L2-L3	1	
CARETOUCH GLUCOSE MONITORING	1	
CARETOUCH LANCING DEVICE	1	
cefaclor oral suspension for reconstitution 125 mg/5 ml, 375 mg/5 ml	1	
CHILDREN'S IBUPROFEN	1	
ciprofloxacin hcl oral tablet 100 mg	1	
CLEVER CHEK BLOOD GLUCOSE	1	
CLEVER CHEK BLOOD GLUCOSE SYST	1	
CLEVER CHOICE BLOOD GLUC SYS	1	
CLEVER CHOICE GLUCOSE MONITOR	1	
CLEVER CHOICE LEVEL 1 CONTROL	1	
CLEVER CHOICE LEVEL 2 CONTROL	1	
CLEVER CHOICE LEVEL 3 CONTROL	1	
CLEVER CHOICE MICRO	1	
CLEVER CHOICE PRO	1	
CLEVER CHOICE TALK GLUCOSE SYS	1	

Drug Name	Drug Tier	Requirements/ Limits
CONTOUR CONTROL SOLUTION, HIGH	1	
CONTOUR CONTROL SOLUTION, LOW	1	
CONTOUR CONTROL SOLUTION, NML	1	
CONTOUR METER	1	
CONTOUR NEXT EZ METER	1	
CONTOUR NEXT GEN METER	1	
CONTOUR NEXT GLUCOSE METER	1	
CONTOUR NEXT LEV 1 CONTROL SOL	1	
CONTOUR NEXT LEV 2 CONTROL SOL	1	
CONTOUR NEXT LINK	1	
CONTOUR NEXT LINK 2.4	1	
CONTOUR NEXT METER	1	
CONTOUR NEXT ONE METER	1	
DENGVAXIA (PF)	1	
desmopressin nasal spray with pump	1	
DEXCOM G6 RECEIVER	1	
DEXCOM G6 SENSOR	1	
DEXCOM G6 TRANSMITTER	1	
DEXCOM G7 RECEIVER	1	
DEXCOM G7 SENSOR	1	
DIATRUE CONTROL SOLN NORMAL	1	
DIATRUE CONTROL SOLUTION HIGH	1	
DIATRUE CONTROL SOLUTION LOW	1	

Drug Name	Drug Tier	Requirements/ Limits
DIATRUE PLUS BLOOD GLUCOSE MET	1	
diclofenac sodium topical gel 1 %	1	QL (1000 GM per 28 days)
DROPLET GENTEEL LANCING DEVICE	1	
DROPLET LANCING DEVICE	1	
EASY MINI EJECT LANCING DEVICE	1	
EASY PLUS II BLOOD GLUCOSE MET	1	
EASY PLUS II HIGH CONTROL	1	
EASY PLUS II LOW CONTROL	1	
EASY STEP BLOOD GLUCOSE METER	1	
EASY STEP HIGH CONTROL SOLN	1	
EASY STEP LOW CONTROL SOLUTION	1	
EASY STEP NORMAL CONTROL SOLN	1	
EASY TALK BLOOD GLUCOSE METER	1	
EASY TALK HIGH CONTROL	1	
EASY TALK LOW CONTROL	1	
EASY TALK PLUS II HIGH CONTROL	1	
EASY TALK PLUS II LOW CONTROL	1	
EASY TOUCH BLU CTRL SOLN-L1,L3	1	
EASY TOUCH BLULINK GLUC SYST	1	
EASY TOUCH GLUCOSE MONITOR	1	
EASY TOUCH HIGH-LOW CONTROL	1	
EASY TOUCH LANCING DEVICE	1	
EASY TRAK BLOOD GLUCOSE METER	1	
EASY TRAK HIGH CONTROL	1	
EASY TRAK II BLOOD GLUCOSE MTR	1	
EASY TRAK II CTRL SOLN-NORMAL	1	
EASY TRAK LOW CONTROL	1	
EASYGLUCO METER	1	
EASYGLUCO MONITORING SYSTEM	1	
EASYMAX 15 LEVEL 2	1	
EASYMAX NG	1	
EASYMAX NORMAL CONTROL	1	
EASYMAX V SPEAKING GLUCOSE SYS	1	
EASY-TOUCH BLOOD GLUCOSE METER	1	
EC-NAPROXEN ORAL TABLET,DELAYED RELEASE (DR/EC) 500 MG	1	
ELEMENT COMPACT GLUCOSE METER	1	
ELEMENT COMPACT HIGH CONTROL	1	
ELEMENT COMPACT NORMAL CONTROL	1	
ELEMENT COMPACT V GLUCOSE MTR	1	

Drug Name	Drug Tier	Requirements/ Limits
ELEMENT HIGH CONTROL	1	
ELEMENT LOW CONTROL	1	
ELEMENT NORMAL CONTROL	1	
ELEMENT PLUS BLOOD GLUCOSE KIT	1	
EMBRACE BLOOD GLUCOSE SYSTEM	1	
EMBRACE EVO BLOOD GLUCOSE KIT	1	
EMBRACE EVO GLUCOSE MONITOR	1	
EMBRACE EVO LEVEL 1	1	
EMBRACE GLUCOSE CONTROL HIGH	1	
EMBRACE GLUCOSE CONTROL LOW	1	
EMBRACE LANCING DEVICE	1	
EMBRACE PRO	1	
EMBRACE PRO GLUCOSE METER	1	
EMBRACE TALK BLOOD GLUCOSE SYS	1	
EMBRACE TALK CONTROL-HIGH (L2)	1	
EMBRACE TALK CONTROL-LOW (L1)	1	
EMBRACE TALK GLUCOSE MONITOR	1	
EMBRACE WAVE PLUS GLUCOSE MTR	1	
ENTYVIO	1	PA; QL (2 EA per 28 days)
ERYTHROCIN (AS STEARATE) ORAL TABLET 250 MG	1	

Drug Name	Drug Tier	Requirements/ Limits
EVENCARE G2	1	
EVENCARE G2 SOLUTION	1	
EVENCARE G3 CONTROL	1	
EVENCARE MINI MONITOR SYSTEM	1	
EVERSENSE E3 SENSOR-HOLDER	1	
EVERSENSE E3 SMART TRANSMITTER	1	
EVOLUTION BLOOD GLUCOSE METER	1	
EVOLUTION NORMAL CONTROL	1	
EZ SMART PLUS SYSTEM	1	
EZ SMART SYSTEM	1	
fentanyl citrate buccal lozenge on a handle	1	PA; QL (120 EA per 30 days)
FORA G20 KIT	1	
FORA G30A	1	
FORA GD50 BLOOD GLUCOSE SYSTEM	1	
FORA HIGH CONTROL	1	
FORA LANCING DEVICE	1	
FORA LOW CONTROL	1	
FORA NORMAL CONTROL	1	
FORA PREMIUM V10 GLUCOSE METER	1	
FORA TEST N'GO VOICE METER	1	
FORA TN'G VOICE METER	1	
FORA V10 KIT	1	

Drug Name	Drug Tier	Requirements/ Limits
FORA V12 BLOOD GLUCOSE SYSTEM	1	
FORA V20 KIT	1	
FORA V30A KIT	1	
FORACARE GD20 GLUCOSE METER	1	
FORACARE GD40A GLUCOSE METER	1	
FORACARE GDH HIGH CONTROL	1	
FORACARE GDH LOW CONTROL	1	
FORACARE GDH NORMAL CONTROL	1	
FREESTYLE CONTROL	1	
FREESTYLE FLASH SYSTEM	1	
FREESTYLE FREEDOM	1	
FREESTYLE FREEDOM LITE	1	
FREESTYLE INSULINX	1	
FREESTYLE LIBRE 3 SENSOR	1	
FREESTYLE LITE METER	1	
FREESTYLE PRECISION NEO METER	1	
FREESTYLE SIDEKICK II	1	
FREESTYLE SYSTEM KIT	1	
GE100 BLOOD GLUCOSE SYSTEM	1	
GE100 CONTROL SOLUTION NORMAL	1	
GE333 BLOOD GLUCOSE SYSTEM	1	
GENTEEL VACUUM LANCING DEVICE	1	

Drug Name	Drug Tier	Requirements/ Limits
GLUCO NAVII GLUCOSE MONITOR	1	
GLUCOCARD 01 METER	1	
GLUCOCARD 01 NORMAL CONTROL	1	
GLUCOCARD EXPRESSION	1	
GLUCOCARD EXPRESSION KIT	1	
GLUCOCARD EXPRESSION SOLUTION	1	
GLUCOCARD SHINE	1	
GLUCOCARD SHINE CONNEX METER	1	
GLUCOCARD SHINE EXPRESS METER	1	
GLUCOCARD SHINE METER	1	
GLUCOCARD SHINE METER KIT	1	
GLUCOCARD SHINE XL METER	1	
GLUCOCARD VITAL	1	
GLUCOCOM BLOOD GLUCOSE	1	
GLUCOCOM CONTROL HIGH	1	
GLUCOSE CONTROL	1	
GLUCOSE KETONE CONTROL SOLN	1	
GOJJI GLUCOSE CNTRL SOL-NORMAL	1	
GOJJI LANCING DEVICE	1	
GUARDIAN 4 TRANSMITTER	1	
GUARDIAN LINK 3 TRANSMITTER	1	
GUARDIAN SENSOR 3	1	

Drug Name	Drug Tier	Requirements/ Limits
HEALTHPRO GLUCOSE MONITOR	1	
HEALTHPRO HIGH-LOW CONTROL	1	
HEALTHY ACCENTS AUTOLET	1	
HUMALOG MIX 50-50 INSULN U-100	1	
HYPOLANCE AST LANCING	1	
INCONTROL LANCING DEVICE	1	
INFINITY CONTROL SOLUTION HIGH	1	
INFINITY CONTROL SOLUTION LOW	1	
INFINITY CONTROL SOLUTION NORM	1	
INFINITY METER KIT	1	
INFINITY STARTER KIT	1	
JAZZ WIRELESS 2 METER KIT	1	
lancing device	1	
lancing device with lancets kit	1	
LANCING SYSTEM	1	
LANZO LANCING DEVICE	1	
levofloxacin intravenous	1	PA
LEVO-T	1	
MEDISENSE	1	
MEDISENSE MID CONTROL	1	
MEDPOINT NORMAL CONTROL	1	
MICRODOT BLOOD GLUCOSE SYSTEM	1	
MICRODOT HIGH-LOW CONTROL	1	
MICRODOT NORMAL CONTROL	1	

Drug Name	Drug Tier	Requirements/ Limits
MICROLET 2 LANCING DEVICE	1	
MICROLET NEXT LANCING DEVICE	1	
MINI LANCING DEVICE	1	
MULTI-LANCET DEVICE 2	1	
MYGLUCOHEALTH CONTROL SOLUTION	1	
MYGLUCOHEALTH KIT	1	
naloxone injection auto-injector	1	
naloxone nasal	1	
nevirapine oral tablet extended release 24 hr 100 mg	1	
NOVAMAX PLUS GLU-KET	1	
olopatadine ophthalmic (eye)	1	
OMNIPOD 5 G6-G7 PODS (GEN 5)	1	
ON CALL EXPRESS CONTROL	1	
ON CALL EXPRESS METER	1	
ON CALL LANCING DEVICE	1	
ONETOUCH DELICA PLUS LANC DEV	1	
ONETOUCH ULTRA CONTROL	1	
ONETOUCH ULTRA2 METER	1	
ONETOUCH VERIO FLEX METER	1	
ONETOUCH VERIO HIGH CONTROL	1	
ONETOUCH VERIO MID CONTROL	1	

Drug Name	Drug Tier	Requirements/ Limits
ONETOUCH VERIO REFLECT METER	1	
paromomycin	1	
PNEUMOVAX-23 INJECTION SYRINGE	1	
prednicarbate topical ointment	1	
PREMIUM BLOOD GLUCOSE MONITOR	1	
PREVNAR 20 (PF)	1	
PRODIGY NO CODING	1	
PRODIGY VOICE GLUCOSE METER	1	
quinapril-hydrochlorothiazide	1	
sodium chloride 0.9 % intravenous piggyback	1	
SOLUS V2 CONTROL SOLUTION, LOW	1	
sumatriptan succinate subcutaneous cartridge 4 mg/0.5 ml	1	QL (8 ML per 28 days)
SUREFLEX DEVICE WITH LANCETS	1	
SURE-PEN LANCING DEVICE	1	
SURE-TEST EASYPLUS MINI SOLUTION	1	
TELCARE CONTROL	1	
TEMPO WELCOME KIT	1	
TEST N'GO BLOOD GLUCOSE SYSTEM	1	
TRUE METRIX AIR GLUCOSE METER	1	
TRUE METRIX GO GLUCOSE METER	1	
TRUE METRIX LEVEL 3	1	
TRUEDRAW LANCING DEVICE	1	
TRUETRACK BLOOD GLUCOSE SYSTEM	1	
TRUETRACK SMART SYSTEM	1	
TRUSTEEL INFUSION SET 23"	1	
TRUSTEEL INFUSION SET 32"	1	
ULTI-LANCE KIT	1	
ULTRATRAK GLUCOSE METER	1	
ULTRATRAK HIGH-LOW CONTROL	1	
ULTRATRAK NORMAL CONTROL	1	
ULTRATRAK ULTIMATE	1	
ULTRATRAK ULTIMATE SOLUTION	1	
UNISTIK 2 DEVICE	1	
UNISTIK 2 EXTRA LANCET	1	
UNISTIK 2 NORMAL LANCET	1	
VARISOFT INFUSION SET 23"	1	
VARISOFT INFUSION SET 32"	1	
VARISOFT INFUSION SET 43"	1	
VAXNEUVANCE (PF)	1	
VIVAGUARD INO GLUCOSE METER	1	
VIVAGUARD INO SMART GLUC METER	1	
VIVAGUARD LANCING DEVICE	1	

Drug Name	Drug Tier	Requirements/ Limits
OPHTHALMIC AGENTS		
OPHTHALMIC AGENTS, OTHER		
atropine ophthalmic (eye) drops 1 %	1	
cyclosporine ophthalmic (eye)	1	QL (60 EA per 30 days)
CYSTARAN	1	PA
dorzolamide-timolol	1	
neomycin-bacitracin-poly-hc	1	
neomycin-polymyxin b-dexameth	1	
neomycin-polymyxin-gramicidin	1	
neomycin-polymyxin-hc ophthalmic (eye)	1	
NEO-POLYCIN	1	
NEO-POLYCIN HC	1	
OXERVATE	1	PA
polymyxin b sulf-trimethoprim	1	
sulfacetamide-prednisolone	1	
tobramycin-dexamethasone	1	QL (10 ML per 14 days)
XDEMVY	1	PA; QL (10 ML per 42 days)
OPHTHALMIC ANTI-ALLERGY AGENTS		
azelastine ophthalmic (eye)	1	
cromolyn ophthalmic (eye)	1	
epinastine	1	

Drug Name	Drug Tier	Requirements/ Limits
OPHTHALMIC ANTI-INFECTIVES		
bacitracin ophthalmic (eye)	1	
bacitracin-polymyxin b	1	
ciprofloxacin hcl ophthalmic (eye)	1	
erythromycin ophthalmic (eye)	1	QL (3.5 GM per 14 days)
gentamicin ophthalmic (eye) drops	1	QL (70 ML per 30 days)
moxifloxacin ophthalmic (eye) drops	1	
NATACYN	1	
neomycin-bacitracin-polymyxin	1	
neomycin-polymyxin-gramicidin	1	
ofloxacin ophthalmic (eye)	1	
POLYCIN	1	
polymyxin b sulf-trimethoprim	1	
sulfacetamide sodium ophthalmic (eye)	1	
tobramycin ophthalmic (eye)	1	QL (10 ML per 14 days)
trifluridine	1	
ZIRGAN	1	
OPHTHALMIC ANTI-INFLAMMATORIES		
dexamethasone sodium phosphate ophthalmic (eye)	1	
diclofenac sodium ophthalmic (eye)	1	
fluorometholone	1	
flurbiprofen sodium	1	
ketorolac ophthalmic (eye)	1	

Drug Name	Drug Tier	Requirements/ Limits
loteprednol etabonate	1	
prednisolone acetate	1	
prednisolone sodium phosphate ophthalmic (eye)	1	
XIIDRA	1	QL (60 EA per 30 days)
OPHTHALMIC BETA-ADRENERGIC BLOCKING AGENTS		
betaxolol ophthalmic (eye)	1	
carteolol	1	
levobunolol ophthalmic (eye) drops 0.5 %	1	
timolol maleate ophthalmic (eye) drops	1	
timolol maleate ophthalmic (eye) gel forming solution	1	
OPHTHALMIC INTRAOCULAR PRESSURE LOWERING AGENTS, OTHER		
acetazolamide	1	
apraclonidine	1	
brimonidine ophthalmic (eye)	1	
dorzolamide	1	
dorzolamide-timolol	1	
methazolamide	1	
PHOSPHOLINE IODIDE	1	
pilocarpine hcl ophthalmic (eye) drops 1 %, 2 %, 4 %	1	

Drug Name	Drug Tier	Requirements/ Limits
OPHTHALMIC PROSTAGLANDIN AND PROSTAMIDE ANALOGS		
latanoprost	1	
tafluprost (pf)	1	
travoprost	1	
OTIC AGENTS		
OTIC AGENTS		
acetic acid otic (ear)	1	
ciprofloxacin hcl otic (ear)	1	
ciprofloxacin-dexamethasone	1	
FLAC OTIC OIL	1	
fluocinolone acetonide oil	1	
hydrocortisone-acetic acid	1	
neomycin-polymyxin-hc otic (ear)	1	
ofloxacin otic (ear)	1	
RESPIRATORY TRACT/ PULMONARY AGENTS		
ANTIHISTAMINES		
azelastine nasal spray,non-aerosol 137 mcg (0.1 %)	1	QL (60 ML per 30 days)
cetirizine oral solution 1 mg/ml	1	
hydroxyzine hcl oral tablet	1	PA
levocetirizine oral solution	1	
levocetirizine oral tablet	1	QL (30 EA per 30 days)
promethazine oral	1	PA

Drug Name	Drug Tier	Requirements/ Limits
ANTI-INFLAMMATORIES, INHALED CORTICOSTEROIDS		
ASMANEX HFA	1	ST; QL (13 GM per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 110 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (30), 220 MCG/ ACTUATION (60)	1	ST; QL (1 EA per 30 days)
ASMANEX TWISTHALER INHALATION AEROSOL POWDR BREATH ACTIVATED 220 MCG/ ACTUATION (120)	1	ST; QL (2 EA per 30 days)
BREZTRI AEROSPHERE	1	QL (10.7 GM per 30 days)
budesonide inhalation suspension for nebulization 0.25 mg/2 ml, 0.5 mg/2 ml	1	BvD; QL (120 ML per 30 days)
budesonide inhalation suspension for nebulization 1 mg/2 ml	1	BvD; QL (60 ML per 30 days)
flunisolide	1	QL (50 ML per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation	1	ST; QL (12 GM per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation	1	ST; QL (24 GM per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation	1	ST; QL (10.6 GM per 30 days)
fluticasone propionate nasal	1	QL (16 GM per 30 days)
ANTILEUKOTRIENES		
montelukast	1	
zafirlukast	1	
BRONCHODILATORS, ANTICHOLINERGIC		
ATROVENT HFA	1	QL (25.8 GM per 30 days)
ipratropium bromide inhalation	1	BvD
ipratropium bromide nasal	1	QL (30 ML per 30 days)
SPIRIVA RESPIMAT	1	QL (4 GM per 30 days)
BRONCHODILATORS, SYMPATHOMIMETIC		
albuterol sulfate inhalation hfa aerosol inhaler 90 mcg/actuation	1	QL (17 GM per 30 days)
albuterol sulfate inhalation solution for nebulization 0.63 mg/3 ml, 1.25 mg/3 ml, 2.5 mg /3 ml (0.083 %), 2.5 mg/0.5 ml	1	BvD
albuterol sulfate oral syrup	1	
albuterol sulfate oral tablet	1	
arformoterol	1	BvD
BREYNA	1	QL (10.3 GM per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
DULERA	1	QL (13 GM per 30 days)
epinephrine injection auto-injector 0.15 mg/0.3 ml, 0.3 mg/0.3 ml	1	QL (4 EA per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 110 mcg/actuation	1	ST; QL (12 GM per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 220 mcg/actuation	1	ST; QL (24 GM per 30 days)
fluticasone propionate inhalation hfa aerosol inhaler 44 mcg/actuation	1	ST; QL (10.6 GM per 30 days)
formoterol fumarate	1	BvD
STRIVERDI RESPIMAT	1	QL (4 GM per 30 days)
terbutaline oral	1	
CYSTIC FIBROSIS AGENTS		
CAYSTON	1	PA; LA; QL (84 ML per 56 days)
KALYDECO	1	PA; QL (56 EA per 28 days)
ORKAMBI ORAL GRANULES IN PACKET	1	PA; QL (56 EA per 28 days)
ORKAMBI ORAL TABLET	1	PA; QL (112 EA per 28 days)
PULMOZYME	1	BvD
SYMDEKO	1	PA; QL (56 EA per 28 days)
tobramycin in 0.225 % nacl	1	PA; QL (280 ML per 28 days)
tobramycin inhalation	1	PA; QL (224 ML per 28 days)
TRIKAFTA ORAL GRANULES IN PACKET, SEQUENTIAL	1	PA; QL (56 EA per 28 days)
TRIKAFTA ORAL TABLETS, SEQUENTIAL	1	PA; QL (84 EA per 28 days)
MAST CELL STABILIZERS		
cromolyn inhalation	1	BvD
cromolyn oral	1	
PHOSPHODIESTERASE INHIBITORS, AIRWAYS DISEASE		
roflumilast	1	PA; QL (30 EA per 30 days)
THEO-24	1	
theophylline oral solution	1	
theophylline oral tablet extended release 12 hr	1	
theophylline oral tablet extended release 24 hr	1	
PULMONARY ANTIHYPERTENSIVES		
ADEMPAS	1	PA; LA
ALYQ	1	PA; QL (60 EA per 30 days)
ambrisentan	1	PA; LA
bosentan	1	PA; LA
OPSUMIT	1	PA; LA
OPSYNVI	1	PA; QL (30 EA per 30 days)
sildenafil (pulm.hypertension) oral tablet	1	PA; QL (90 EA per 30 days)
tadalafil (pulm. hypertension)	1	PA; QL (60 EA per 30 days)
UPTRAVI ORAL	1	PA; LA

Drug Name	Drug Tier	Requirements/ Limits
PULMONARY FIBROSIS AGENTS		
FRUZAQLA ORAL CAPSULE 1 MG	1	PAns; QL (84 EA per 28 days)
FRUZAQLA ORAL CAPSULE 5 MG	1	PAns; QL (21 EA per 28 days)
OFEV	1	PA; QL (60 EA per 30 days)
pirfenidone oral capsule	1	PA; QL (270 EA per 30 days)
pirfenidone oral tablet 267 mg	1	PA; QL (270 EA per 30 days)
pirfenidone oral tablet 801 mg	1	PA; QL (90 EA per 30 days)
ROZLYTREK ORAL PELLETS IN PACKET	1	PAns; QL (336 EA per 28 days)
RESPIRATORY TRACT AGENTS, OTHER		
acetylcysteine	1	BvD
BREYNA	1	QL (10.3 GM per 30 days)
BREZTRI AEROSPHERE	1	QL (10.7 GM per 30 days)
DUPIXENT PEN SUBCUTANEOUS PEN INJECTOR 300 MG/2 ML	1	PA; QL (8 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 200 MG/1.14 ML	1	PA; QL (4.56 ML per 28 days)
DUPIXENT SYRINGE SUBCUTANEOUS SYRINGE 300 MG/2 ML	1	PA; QL (8 ML per 28 days)
fluticasone propion-salmeterol inhalation blister with device	1	QL (60 EA per 30 days)
STIOLTO RESPIMAT	1	QL (4 GM per 30 days)
WIXELA INHUB	1	QL (60 EA per 30 days)
RESPIRATORY TRACT/ PULMONARY AGENTS		
BREZTRI AEROSPHERE	1	QL (10.7 GM per 30 days)
COMBIVENT RESPIMAT	1	QL (8 GM per 30 days)
ipratropium-albuterol	1	BvD
SKELETAL MUSCLE RELAXANTS		
SKELETAL MUSCLE RELAXANTS		
cyclobenzaprine oral tablet 10 mg, 5 mg	1	PA
SLEEP DISORDER AGENTS		
SLEEP PROMOTING AGENTS		
BELSOMRA	1	PA; QL (30 EA per 30 days)
doxepin oral tablet	1	QL (30 EA per 30 days)
ramelteon	1	QL (30 EA per 30 days)
zaleplon oral capsule 10 mg	1	QL (60 EA per 30 days)
zaleplon oral capsule 5 mg	1	QL (30 EA per 30 days)
zolpidem oral tablet	1	QL (30 EA per 30 days)

Drug Name	Drug Tier	Requirements/ Limits
WAKEFULNESS PROMOTING AGENTS		
armodafinil	1	PA; QL (30 EA per 30 days)
modafinil oral tablet 100 mg	1	PA; QL (30 EA per 30 days)
modafinil oral tablet 200 mg	1	PA; QL (60 EA per 30 days)
sodium oxybate	1	PA; LA; QL (540 ML per 30 days)

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Contact us

Prospective Members:
1-800-944-1247

Current Members:
1-800-942-0247

TTY: 711

Hours:
8:00 a.m. to 8:00 p.m.
7 days a week

This formulary was updated on 11/19/2024. For more recent information or other questions, please contact Community Health Plan of Washington Dual Complete and Dual Select (HMO D-SNP) Customer Service at 1-800-942-0247 or for TTY users, dial 711, 7 days a week, 8 a.m. to 8 p.m. or visit our website at medicare.chpw.org. **Important Message About What You Pay for Vaccines** - Our plan covers most Part D vaccines at no cost to you. Call Customer Service for more information. **Important Message About What You Pay for Insulin** - You will pay $0 for a one-month supply of each insulin product covered by our plan.

Changes to our formulary network may occur during the benefit year. An updated formulary is located on our website at medicare.chpw.org. You may also call Customer Service for updated information.

COMMUNITY HEALTH PLAN of Washington™
MEDICARE ADVANTAGE

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